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Institut de recherche et documentation en économie de la santé
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Veille scientifique
en économie de la santé

Watch on Health Economics Literature

Avril 2026 / April 2026

Assurance maladie	*Health Insurance*
E-Santé – Technologies médicales	*E-health – Medical Technologies*
Économie de la santé	*Health Economics*
Environnement et santé	*Environmental Health*
État de santé	*Health Status*
Géographie de la santé	*Geography of Health*
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ABSTRACT Patient cost-sharing can lead to delays in necessary care, especially among low-income populations. In this study, we examine the impact of health insurance coverage for chronic disease treatments in outpatient care, using recent administrative insurance claims dataset from a low-income population in an underdeveloped city in China. Employing a propensity score matching and difference-in-differences approach, we find that outpatient coverage for certain chronic diseases increased outpatient utilization and expenses among patients with these conditions. Interestingly, these patients also increased their use of inpatient services, despite no changes in the cost-sharing for inpatient care. Our findings suggest the presence of delayed care, where outpatient visits helped patients recognize the severity of their diseases and increased the demand for inpatient care. These results have important implications for the implementation of universal health coverage and the dynamics of healthcare costs in low- and middle-income countries.

The Effect of Ending the Pandemic-Related Mandate of Continuous Medicaid Coverage on Health Insurance Coverage and Economic Well-Being

DASGUPTA, K. ET SOLOMON, K. T.

2026

Health Services Research 61(1): e70021.

https://doi.org/10.1111/1475-6773.70021

ABSTRACT Objective To investigate the effect of the unwinding of the pandemic-related continuous Medicaid enrollment provision on health insurance coverage and economic hardship. Study Setting and Design The termination of the continuous Medicaid enrollment provision during early 2023 and the subsequent state-level resumption of the standard renewal process prompted large-scale Medicaid disenrollments nationwide. Using state-month variation in the incidence of the first round of disenrollments, we estimate the effects of the unwinding process on health insurance coverage, including Medicaid enrollment, and the likelihood of experiencing economic hardship for the adult population. Data Sources and Analytic Sample We use state-level monthly Medicaid enrollment data from the Centers for Medicare and Medicaid Services and self-reported individual-level indicators of Medicaid coverage, being uninsured, and economic hardship from the U.S. Census Bureau's Household Pulse Survey. Our key findings are substantiated by evidence drawn from recent annual data from the Current Population Survey and the Survey of Household Economics and Decision making. Principal Findings States' unwinding of the continuous Medicaid enrollment provision reduced state-level Medicaid enrollment by 4% [−0.071–0.004]. We do not, however, find statistically significant effects on changes in the probability of being without any health coverage and experiencing economic hardship for the overall adult population. However, further evidence reveals that the effects can be heterogeneous depending on demographic and educational characteristics. Conclusions The unwinding of the continuous Medicaid enrollment provision reduced overall Medicaid enrollments. However, there is no evidence that these provisions changed the probability of being uninsured and experiencing economic hardship for the general adult population. This study opens an important research scope for investigating the long-term implications of unwinding large-scale pandemic-related relief measures.

Effects of Continuous Medicaid Coverage in 2020–2023 on Children's Health Insurance Coverage, Access to Care, Health Services Use by Type, and Health Status

LYU, W. ET WEHBY, G. L.

2026

Health Services Research 61(1): e70034.

https://doi.org/10.1111/1475-6773.70034

ABSTRACT Objective To examine the effects of continuous Medicaid coverage in 2020–2023 under the

Families First Coronavirus Response Act (FFCRA) on children's health insurance coverage, access to care, likelihood of using healthcare services by type, and health status. Study Setting and Design A difference-in-differences event study compares outcomes pre and post FFCRA between states without pre-FFCRA continuity provisions (treatment group) and those that required 12-month continuous coverage (control group).Data Sources and Analytical Sample The main sample includes 122,901–126,117 children (depending on outcome) aged 1–17 years with family income below 300% of federal poverty level from the 2016–2023 National Survey of Children's Health. Primary Findings After FFCRA, public coverage increased in treatment states in 2020, 2021, and 2022 by 4.1 (95% CI: 0.004, 8.3), 4.7 (95% CI, 0.4, 9.0), and 5.4 (95% CI: 2.0, 8.7) percentage points, respectively, relative to control states. Privately purchased coverage declined in 2020 by 3.5 (95% CI: −5.3, −1.7) percentage points. The likelihood of having a usual place for sick care increased by 3.6 (95% CI: 0.5, 6.8) percentage points in 2021, and the likelihood of unmet care needs decreased by 1.7 (95% CI: −2.8, −0.7) and 2.4 (95% CI: −3.8, −1.0) percentage points in 2021 and 2022. The likelihood of excellent/very good health increased by 2.5 (95% CI: 0.4, 4.5), 3.8 (95% CI: 0.7, 6.8), and 2.7 (95% CI: 0.4, 5.0) percentage points in 2020, 2021, and 2023, respectively. There were no changes in the likelihood of medical, preventive, mental health, specialist, and emergency department visits and hospital admissions. Conclusions Medicaid continuity under the FFCRA increased the children's public coverage rate. Despite potential switching from private coverage, there is evidence for reductions in unmet care needs and improved health status. Findings provide insights into potential effects of recent federal requirements that all states provide 12-month Medicaid continuity for children.

▶ Access To Dental Care Among People Newly Eligible For A Medicare Dental Benefit

SIMON, L. ET DALEY, N.

2026

Health Affairs 45(1): 92-96.

https://doi.org/10.1377/hlthaff.2025.00636

Our analysis of 2017–22 Medicare Current Beneficiary Survey data found that approximately 1.31 million Medicare fee-for-service beneficiaries annually were eligible for a dental benefit established in 2023. Eligible beneficiaries were just as likely to have dental insurance as fee-for-service beneficiaries who were ineligible for the benefit.

E-santé / Technologies médicales

E-Health / Medical Technologies

▶ Les données ouvertes au service de l'économie de la santé : l'expérience de l'enquête SHARE

JUSOT, F. ET RENAUD, T.

2025

Revue économique 76(5): 773-802.

https://doi.org/10.3917/reco.765.0773

La science ouverte, qui vise à rendre recherches et données librement et rapidement accessibles, transforme en profondeur l'économie de la santé. Cette discipline, à l'intersection de l'économie et de la santé publique, traite de l'allocation efficiente et équitable des ressources sanitaires, des déterminants économiques de la santé ou de la performance des systèmes de santé. Ces enjeux nécessitent une recherche transparente et collaborative fondée sur une large ouverture des données, qui se heurte à de nombreux défis : utilisation de données personnelles sensibles, sources multiples et complexes et pratiques scientifiques divergentes entre disciplines. L'enquête SHARE constitue depuis 2003 une expérience fructueuse d'ouverture des données. L'exemple de cette enquête internationale, longitudinale et multidisciplinaire en open data illustre l'importance de la gouvernance, des normes de qualité des données, de la stratégie de documentation et de formation des utilisateurs, d'un financement pérenne et d'un réseau actif de chercheurs.

Artificial Intelligence Payment Policies: Challenges For CMS And The Medicare Physician Fee Schedule

LONGYEAR, R. L. ET BERENSON, R. A.
2026
Health Affairs 45(1): 14-21.
https://doi.org/10.1377/hlthaff.2025.00672

The proliferation of artificial intelligence (AI) clinical decision support technologies requires careful consideration of payment policies under the Medicare Physician Fee Schedule. In this Policy Insight, we identify key challenges faced by policy makers and the Centers for Medicare and Medicaid Services (CMS), and we discuss the interplay between the Medicare Physician Fee Schedule and the adoption of AI technologies in care delivery. The resource-based relative value scale methodology, which determines Medicare Physician Fee Schedule rates, was not designed for software-based technologies and requires both comprehensive adaptation and implementation reform. We recommend developing a policy framework for coverage determinations for AI technologies, reforming the resource-based relative value scale, creating clear reimbursement pathways for AI technologies, and implementing cost-effectiveness analysis to ensure that marginal Medicare expenditures yield proportional improvements in health care delivery and outcomes.

The DOGE Ate My Data: Lessons from Europe for Rebuilding the US Health Data Linkage Infrastructure After Trump

LYNCH, J. ET TU, M.
2026
Journal of Health Politics, Policy and Law 51(2): 237-260.
https://doi.org/10.1215/03616878-12262648

Health data linkage systems are essential for understanding and addressing health inequalities, yet the US system—already constrained by legal and institutional limitations—has been further eroded by the second Trump administration's policies. These include defunding data collection, politicizing inequality-related research, and breaching privacy rules that protect personal data. This article draws on documentary analysis, secondary data, and comparative institutional review to document recent changes to US health data infrastructure and evaluate alternative models from France, Sweden, and England. The authors find that the Trump administration's actions have severely undermined the US health data linkage system, disrupting the production of data and undermining public trust. A centralized system like Sweden's offers broad data linkage capacity but may not be feasible in the United States because of privacy concerns. France's tight controls on access limit usability to elite analysts, exacerbating inequality. England's nascent system offers a model for equitable access to data on social, economic, and political determinants of health. Rebuilding the US health data linkage infrastructure after Trump will require restoring public trust, restoring collection of key sociodemographic indicators, and ensuring equity in access. International examples provide guidance for a more politically sustainable, inclusive system.

Les enjeux socio-économiques de l'IA en santé

MILCENT, C.
2026
Santé Publique vol. 38(1): 7-10.
https://stm.cairn.info/revue-sante-publique-2026-1-page-7

Le développement de l'intelligence artificielle (IA) en santé ouvre de larges perspectives pour réduire les inégalités socio-économiques et territoriales d'accès aux soins. Toutefois, ces promesses reposent sur des choix techniques, organisationnels et réglementaires qui ne sont pas neutres sur le plan social. Ces choix structurant le déploiement de l'IA peuvent tout autant corriger des inégalités existantes que les renforcer, notamment lorsqu'ils reposent sur des données biaisées ou des pratiques hétérogènes.

Medicare Spending On Artificial Intelligence: Payment Policy Is Only Part Of The Story

NEPRASH, H. T.
2026
Health Affairs 45(1): 26-28.
https://doi.org/10.1377/hlthaff.2025.01392

The rapid growth of clinical artificial intelligence (AI) applications poses a unique challenge to Medicare's prospective payment systems, with two issues at the forefront. First, the productivity gains from AI may dwarf those of previous non-AI innovations, but they are uncertain and will take time to realize. Second, AI forces the Centers for Medicare and Medicaid Services (CMS) to think very differently about software. For many clinical applications of AI, the software itself is the ser-

vice. It does not make sense to treat this expense as overhead, but direct reimbursement will likely exceed the true cost of using AI. Finally, although CMS currently pays for only a small fraction of all AI-enabled medical devices approved by the Food and Drug Administration, Medicare may already be spending more on AI as a result of additional AI-generated findings and follow-up care.

Economie de la santé

Health Economics

Too Sick to be True? Evaluating Potentially Problematic Diagnosis Coding Practices in Medicare's Patient-Driven Payment Model

AMARAVADI, H., *et al.*

2026

Health Services Research 61(2): e70084.

https://doi.org/10.1111/1475-6773.70084

ABSTRACT Objective To use a quasi-experimental design to quantify changes in skilled nursing facility (SNF) diagnosis documentation associated with Medicare's Patient-Driven Payment Model (PDPM). PDPM aims to promote patient-centered care in skilled nursing facilities (SNFs) by matching reimbursement to patient characteristics, including clinical complexity, which is captured in part through documentation of diagnoses. Study Setting and Design We used a difference-in-differences design to estimate PDPM's effects on SNF diagnosis documentation, including the number of diagnoses and clinical complexity scores via the Elixhauser comorbidity index. Hospital claims served as a non-equivalent dependent variable control. Triple interaction terms in fixed effect linear models assessed variation by SNF profit status. Changes in the probability of recording five documentation-sensitive conditions were estimated via marginal effects from generalized linear models. Data Sources and Analytic Sample Secondary analysis of 100% Traditional Medicare claims (2018–2021), comprising over 4.8 million hospital-to-SNF episodes. Principal Findings Compared against hospital claims from hospital-SNF episodes, PDPM announcement was associated with 0.83 additional diagnoses on SNF claims, representing a relative increase of 7.1%. Similarly, Elixhauser scores increased by 0.88 points (relative 13.6%). We observed significant variation by profit status; when accounting for anticipatory behavior, profit status was associated with an additional relative 2.8% in diagnoses and 4% in Elixhauser points. PDPM was also associated with increased probability of documenting all five documentation-sensitive conditions: 3.9 percentage points (pp) for chronic pulmonary disease, 5.0 pp for complicated diabetes, 2.8 pp for heart failure, 7.3 pp for obesity, and 9.8 pp for weight loss (all reported $p < 0.001$). Conclusions PDPM was associated with increased coding intensity across multiple measures—and more so in for-profit SNFs—highlighting the need to further evaluate whether SNFs are accurately documenting or falsely inflating clinical complexity. Sustaining Medicare's payment accuracy will require continued monitoring of diagnosis coding behavior and its alignment with actual clinical complexity.

Financial epidemiology: Linking financialization to population health

BRUCH, J. D. ET THURSTON, C.

2026

Social Science & Medicine 392: 118930.

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Financialization represents a pivotal transformation in modern capitalism. We argue that public health scholars and practitioners must attend to financialization – recognizing that financial institutions, markets, and motives have amassed significant power over large swaths of social and economic life and have the potential to transform population health. We begin by providing an overview of the financial industry and financialization. We then describe the channels through which financialization may impact health outcomes. We conclude by calling for a new disciplinary approach focused on critically examining the role of finance in shaping population health, which we refer to as financial epidemiology. We assert that financial epidemiology invites a new and uncharted line of inquiry addressing some of the most pressing issues in this era of financialization.

Do Prices Matter for Healthcare Accessibility? Evidence From a Means-Tested Complementary Health Insurance in France

CARRÉ, B., *et al.*

2026

Health Economics 35(4): 609-637.

https://doi.org/10.1002/hec.70070

ABSTRACT In France, the Couverture Maladie Universelle Complémentaire (CMU-C) scheme is a means-tested, state-financed, complementary health insurance program that fully covers healthcare. Using administrative claims data and a staggered difference-in-differences approach, we estimate the impact of enrollment in the program on healthcare utilization. To address selection into the program, we use health shocks at the family level to exogenize individual enrollment. The findings indicate that access to free healthcare significantly increases healthcare utilization at both intensive and extensive margins. This effect is driven primarily by individuals who are uninsured before enrolling in the CMU-C. Moreover, individuals with severe or chronic illnesses, who already receive additional public coverage for their conditions, experience significant gains from the CMU-C coverage. Finally, these effects persist throughout the coverage period.

Poverty and access to health care: the political economy of redesigning user charges in the context of fiscal pressure

CYLUS, J., THOMSON, S., HABICHT, T., *et al.*

2026

European Journal of Public Health 36(Supplement_2): ii30-ii35.

https://doi.org/10.1093/eurpub/ckaf219

Global and regional commitments to universal health coverage emphasize reducing financial hardship due to out-of-pocket payments for health care. Despite this, many countries continue to rely on user charges—either to raise revenue or reduce demand—especially under fiscal pressure. We conducted a narrative review of academic literature on the theoretical basis for and empirical effects of user charges in health systems. This was complemented by recent case studies from Slovenia, Estonia, and Cyprus, selected to illustrate diverse approaches to user charge policy under fiscal constraints. Common arguments in favour of user charges are that they can mitigate excess health care consumption and generate revenues. However, evidence suggests they often deter necessary care and lead to financial hardship, especially for low-income groups. Country case studies reveal varied approaches towards user charges in the context of fiscal pressure: Estonia increased co-payments despite prior efforts to improve financial protection; Slovenia eliminated user charges by introducing a flat levy to generate additional revenue; and Cyprus dramatically reduced its reliance on out-of-pocket payments by increasing public spending on health. Growing fiscal pressure may tempt countries to implement or increase user charges. However, doing so without adequate protective mechanisms can increase financial hardship, poverty and unmet health needs. Policymakers should prioritize pre-payment mechanisms and equity-oriented safeguards to ensure sustainable, fair and affordable access to health care. Continuous monitoring of financial hardship remains essential to inform policy decisions.

Learning The Limits Of Health Care Sharing Plans

FUDENNA, E.

2026

Health Affairs 45(1): 97-100.

https://doi.org/10.1377/hlthaff.2025.00236

After emergency brain surgery, a college student learned that her health care sharing plan would cover none of the costs.

Mechanisms Considering Public Investment in Pricing and Reimbursement Decisions of Medicines and Other Health Technologies: A Scoping Review

GARCÍA-DÍAZ, M., *et al.*

2026

Applied Health Economics and Health Policy 24(1): 131-146.

https://doi.org/10.1007/s40258-025-00994-5

Pricing and reimbursement (P&R) systems do not normally use public investments in research and development (R&D) as criteria when negotiating the prices and reimbursement of health technologies.

Anatomy Of A Slowdown: Decomposing The Moderation In Health Spending Growth, 2009–19

GLIED, S. A. ET LUI, B.

2026

Health Affairs 45(1): 29-38.
https://doi.org/10.1377/hlthaff.2025.00472

National health expenditure growth between 2009 and 2019 slowed to less than half the historical rate of growth seen between 1970 and 2008. To identify why, we gathered actuarial projections of the fiscal effects of policies implemented between 2009 and 2019, netted these out from the 2009 Centers for Medicare and Medicaid Services baseline projections of national health expenditures, and decomposed the residual differences by payer and service to shed light on the spending slowdown. We identified four trends that contributed to spending growth below the baseline projections: declining utilization and substitution of lower-cost alternatives across hospitals, physicians, and pharmaceuticals; slow private hospital and physician price growth and the expanding scope of practice of nonphysicians in office-based settings; declining home health use among the oldest Medicaid beneficiaries; and slow growth in private insurers' administrative spending. Our results raise questions about several of the assumptions that underlay previous forecasts of future health care spending.

Income–Well-Being Gradient in Sickness and Health

KANNINEN, O., *et al.*

2026

Health Economics 35(3): 409-422.
https://doi.org/10.1002/hec.70063

ABSTRACT We propose a method for studying the value of insurance. For this purpose, we analyze the well-being of the same individuals, comparing sick and healthy years, using German panel survey data on life satisfaction. We impose structure on the income–well-being gradient by fitting a flexible utility function to the data, focusing on the differences in marginal utility in the sick and the healthy states. Notably, our empirical specification allows for a "fixed cost of sickness." We find a higher marginal utility of income in the sick state. We use our estimates to gauge the value of sickness insurance for Baily-Chetty–type optimal policy calculations.

The Impact of Health Insurer Acquisitions of Physician Practices on Prices and Patient Visits

LAKE, D. T., *et al.*

2026

Health Services Research 61(2): e70025.
https://doi.org/10.1111/1475-6773.70025

ABSTRACT Objective To investigate whether the acquisition of physician practices by Optum, a subsidiary of United Health Group (UHG), influences patient volume and service prices, particularly, for patients enrolled in health insurance plans competing with UHG. Study Setting and Design We employed a novel database cataloging health insurer acquisitions of physician practices to identify those acquired by Optum - the nation's largest payvider (vertically integrated payer-provider)-from 2007 to 2023. These data were integrated with non-UHG commercial health insurance claims for practices acquired between 2015 and 2019. Using a stacked difference-in-differences design, we analyzed relative changes in prices and office visits across 12 Optum-acquired practices compared to a control group. Adjustments were made for physician profiles, practice characteristics, and calendar-year fixed effects to ensure robust estimates. Principal Findings From 2007 to 2023, Optum acquired 44 physician practices, employing 7828 physicians by 2023. Postacquisition, we found no statistically significant average change in prices for most acquired practices relative to controls. However, the single largest acquisition was associated with a relative price increase of 4.5% (95% CI: [1.2%, 7.8%]; p=0.02) for established patient visits. Preacquisition trends showed prices at acquired practices rising faster than controls. Additionally, Optum acquisitions were linked to suggestive declines in claim volume 1?1.5 years postacquisition, though this shift was predominantly driven by the largest acquired practice, indicating variability in outcomes across the sample. Conclusions Optum's acquisition of physician practices did not broadly result in significant price changes for evaluation and management services provided to patients with competing insurance plans, despite higher baseline prices at acquired practices. Suggestive reductions in patient volume emerged postacquisition, but effects were inconsistent. Extended follow-up research is warranted to evaluate whether these acquisitions reshape local healthcare market dynamics over time.

Impact of prospective payment systems: An umbrella review of systematic reviews

LEFÈVRE, M., *et al.*

2026

Health Policy 165: 105552.

https://doi.org/10.1016/j.healthpol.2025.105552

Background Prospective payment systems are widely used in OECD countries and beyond to reimburse hospital care. Objective To evaluate the impact of prospective payments systems on the quality of patient care, healthcare efficiency, volume of activity, and hospital costs. Methods Umbrella review by searching three electronic databases for systematic reviews with or without meta-analyses published between 2014 and July 2025. The quality of the included studies was assessed with AMSTAR 2, and tables were constructed to display the characteristics and results of the retrieved publications. Results Ten systematic reviews were identified that evaluated the impact of prospective payment systems on healthcare efficiency, quality of care, volume of activity and costs. Most of the included reviews drew upon relatively recent primary studies and were of moderate to high methodological quality. Regarding efficiency, most reviews demonstrated that the implementation of prospective payment systems leads to a reduction in hospital length of stay. The umbrella review did not identify substantial evidence of a negative impact on the quality of care. The impact on healthcare costs was less consistently reported, and findings were inconclusive. The evidence on activity volume is also mixed. Conclusions This review supports the theoretical assumption that prospective payment systems incentivise greater efficiency in healthcare delivery, without detrimental effects on quality of care. However, these conclusions are limited by the heterogeneity of the included payment programmes, contexts, and accompanying interventions, that make it challenging to attribute observed impacts directly to the payment system.

Willingness to Pay per QALY: A Systematic Review of Demand-Side Valuations with a Focus on Age and Disease Severity

LOUPAS, M. A., *et al.*

2026

Applied Health Economics and Health Policy 24(1): 47-63.

https://doi.org/10.1007/s40258-025-01005-3

Willingness-to-pay (WTP) studies offer a demand-side perspective on the monetary value of health gains, typically expressed as WTP per quality-adjusted life year (WTP/Q). These estimates can complement supply-side cost-effectiveness thresholds (CETs) and inform whether healthcare budgets align with public preferences. However, existing thresholds often overlook heterogeneity by condition or population characteristics.

Bundled Payment Programs and Changes in Practice Patterns and Episode Spending in Major Gastrointestinal Surgery

MULLENS, C. L., *et al.*

2026

Health Services Research 61(1): e70046.

https://doi.org/10.1111/1475-6773.70046

ABSTRACT Objective To evaluate the association between enrollment in the Bundled Payments for Care Improvement –Advanced (BPCI-A) program and changes in utilization of minimally invasive surgery and 90-day episode spending for patients undergoing major gastrointestinal surgery. Study Setting and Design compared hospitals that voluntarily enrolled in BPCI-A to control hospitals that did not participate. We used entropy balancing to reweight controls to match the BPCI-A cohort based on observable patient and hospital characteristics. We then used a difference-in-differences approach to estimate the association between surgical approach and 90-day episode payments. Data Sources and Analytic Sample We used Medicare claims and American Hospital Association data between 2013 and 2021 to evaluate whether hospital enrollment in the BPCI-A program was associated with changes in 90-day episode spending and utilization of minimally invasive surgical approaches. Using entropy balancing, we reweighted the control group to achieve covariate balance with beneficiaries who obtained care at BPCI-A program hospitals. We performed a difference-in-differences analysis using multivariable linear and generalized linear models, adjusting for patient demographics, comorbidities, and hospital characteristics, with standard errors clustered at the hospital-year level to evaluate these outcomes. Principal Findings Changes in 90-day episode payments at BPCI-A program hospitals versus non-program hospitals were not significantly different (–$172, 95% CI: –$1104 to $760). In comparing trends at BPCI-A program and control hospitals, we identified no significant differences in utilization trends for minimally invasive surgical approaches (relative risk difference: –0.003, 95% CI: –0.10 to 0.04). The similarity in utilization trends

between BPCI-A program and control hospitals was observed in the context of increasing overall utilization of MIS approaches from 40.3 to 38.4 to 43.9 to 42.9 during the study period, respectively. Conclusions We found no evidence that hospitals participating in BPCI-A's major bowel surgery episodes led to differences in episode spending or utilization of minimally invasive surgical approaches.

Financial Incisors: Cutting Through the Effects of Private Equity on Dentistry Market Dynamics and Care Delivery

NASSEH, K., *et al.*

2026

Health Services Research 61(2): e70075.

https://doi.org/10.1111/1475-6773.70075

ABSTRACT Objective To assess how private equity ownership affects prices, service mix, and Medicaid participation in dentistry at the practice level. Study Setting and Design We utilize a proprietary dental office database linked to administrative dental commercial claims data to estimate the effects of private equity ownership on the financial and operational outcomes of dental offices, employing a staggered difference-in-differences panel design that addresses the nonrandom acquisitions of facilities by private equity firms. Data Sources We rely on private equity transaction data from 2015 to 2021, longitudinal dental office data from the 2015 to 2017 and 2019 to 2021 American Dental Association dental office database, and aggregated commercial dental insurance price and utilization data from 2015 to 2021.Principle Findings Following acquisition, private equity-owned dental offices increased charges for dental care services by 3.3% (95% CI: 2.3%–4.4%), although allowed prices for these services remained statistically unchanged. Dental offices acquired by private equity firms tended to shift from diagnostic and preventive procedures to generally higher reimbursement restorative, specialty, and surgical procedures. Dental offices were more likely to become multispecialty practices after being acquired by a private equity firm. Conclusions Allowed or negotiated prices between dentists and payers did not change in dental offices after being acquired by private equity. Nevertheless, list prices for dental services increased in private equity-owned practices, meaning higher prices can still be passed on to patients. Private equity firms can enhance dental practice revenue by shifting from preventive procedures to higher-cost restorative procedures while not reimbursing providers at a higher amount. In other words, financial enhancement of dental practices under private equity may not translate into benefits for providers or patients. Policymakers should be aware of the effects private equity acquisition has on provider and patient welfare.

Does Health-Based Prospective Risk Adjustment Adequately Compensate for Individuals Diagnosed With a New Chronic Disease?

OSKAM, M., *et al.*

2026

Medical Care Research and Review 83(2): 128-143.

https://doi.org/10.1177/10775587251378167

Many regulated health insurance markets use prospective risk adjustment (RA) to mitigate risk selection incentives for insurers. However, prospective RA might underpay insurers for people diagnosed with a new chronic disease. By tracking spending and RA payments over the period t–2 to t+2 for individuals diagnosed with a new chronic disease in year t, we find a substantial payment gap in year t and, to a lesser extent, in prior and/or subsequent years. The extent to which these gaps stimulate selection incentives for insurers depends on the possibilities for insurers to distort consumers' choice of insurance products. Possibilities which—in turn—depend on whether and when consumers respond to the onset of the chronic disease when choosing an insurance product. By analyzing "insurer switching" in the period t–2 to t+2 we find that—on average—people first diagnosed with a chronic disease are more likely to switch insurer than others.

Clinician Specialties, Quality Score and Shared Savings Receipt in Accountable Care Organizations

OUAYOGODÉ, M. H. ET LIANG, X.

2026

Health Services Research 61(1): e70033.

https://doi.org/10.1111/1475-6773.70033

ABSTRACT Objective To assess the relationship between the changing Accountable Care Organizations-ACO workforce and ACOs' shared savings earnings and quality performance. Data Sources Medicare Shared Savings Program-MSSP provider-level research identifiable files, performance year financial and quality report public use files, and National Physician Compare

data (2013–2021).Study Setting and Design characterized 865 MSSPs, separately pre- (2013–2019) and post-pandemic (2020–2021) according to the percentage of primary care physicians (PCPs), non-physicians, specialists, and other specialty, financial risk model, assigned Medicare beneficiary demographics, clinical risk factors, and provider supply by specialty within the MSSP's primary service state, (total and per-capita) shared savings earnings/losses owed and quality score. Longitudinal ordinary least-squares regressions with random effects were estimated to assess the association between MSSP provider specialty mix and annual (1) per-capita shared savings/losses and (2) quality score, controlling for risk model, beneficiary characteristics, provider supply, and year factors. We also compared outcomes across MSSPs, 32 Pioneers and 62 Next Generation-NGACOs. Principal Findings PCPs represented 33.9% of MSSP's workforce, on average. Higher percentages of PCPs and non-physicians were associated with higher per-capita earned shared savings and quality scores among MSSPs. A 1-percentage-point (ppt) increase in PCPs and non-physicians was associated with higher per-capita shared savings of \$2.25 ($p < 0.01$) and \$1.82 ($p = 0.03$), respectively, pre-COVID, and \$2.73 ($p < 0.01$) and \$1.81 ($p = 0.14$) post-COVID. We estimated increases in quality scores among MSSPs of ~0.1 ppt with a 1 ppt increase in PCPs, non-physicians, and specialists only pre-pandemic. No statistically significant relationships were estimated between provider specialty mix and performance measures in Pioneers and NGACOs. Conclusions Higher percentages of PCPs and non-physicians were associated with higher per-capita shared savings earnings and quality scores among MSSPs. As new federal initiatives continue to unfold, value-based payment models increasing incentives for primary care should be monitored to determine their ability to further improve care efficiency.

The Economic Cost of Obesity: A Cost-of-Illness Study in Greece

PAPANTONIOU, P. ET MANIADAKIS, N.

2026

Applied Health Economics and Health Policy 24(1): 195-215.

https://doi.org/10.1007/s40258-025-01002-6

Obesity represents a significant public health and economic problem worldwide. In Greece, where the prevalence of adult obesity is among the highest in Europe, no prior study has examined its economic impact among adults. This study estimates the total economic burden of obesity in Greece for 2024, adopting a societal perspective and considering both direct and indirect costs.

Bundled Payments For Care Improvement Advanced: Effects On Hospital And CMS Spending, 2018–21

RYAN, A. M., *et al.*

2026

Health Affairs 45(2): 121-128.

https://doi.org/10.1377/hlthaff.2025.00459

The Bundled Payments for Care Improvement Advanced Model (BPCI-A) aims to reduce hospital spending and generate savings for the Centers for Medicare and Medicaid Services (CMS). The design of BPCI-A evolved across four model years; however, previous analyses have not examined its impact on hospital and CMS spending throughout this period. We conducted a synthetic difference-in-differences analysis with a 100 percent sample of Medicare fee-for-service beneficiary data from the period April 2014 through December 2021 to evaluate spending changes across 883 participating hospitals and 1,772 nonparticipating hospitals. BPCI-A led to an average \$324 reduction in hospitals? ninety-day episode spending, with larger reductions in model years 3 and 4. The largest spending reductions were for orthopedics and neurological care. Yet large incentive payments to hospitals led to net CMS losses of \$171 million during the study period, despite net savings in model year 4. BPCI-A reduced payments to skilled nursing facilities during the study period. Thus, BPCI-A had minimal impact on the CMS budget while shifting payments to hospitals and away from skilled nursing facilities. Our results suggest that voluntary bundled payment is unlikely to generate meaningful savings for CMS.

Association of VA Medication Copayment Restructuring With Pharmacy Use, Medication Costs, and Financial Burden of Medications

STROUPE, K. T., *et al.*

2026

Medical Care Research and Review 83(1): 55-66.

https://doi.org/10.1177/10775587251356369

In February 2017, the Department of Veterans Affairs (VA) restructured outpatient medication copayments,

creating three medication tiers comparable with private-sector value-based insurance designs (with copayments: US$5, US$8, US$11 per 30-day supply for Tiers 1–3, respectively); however, Veteran medication management experiences have not been assessed following this change. We invited a random sample of Veterans with chronic conditions (e.g., diabetes, hypertension) who utilized VA services to complete a mailed survey about VA and non-VA pharmacy use and medication management experiences following this restructuring. There were 2,884 respondents (29% response rate). Veterans with the lowest proportion of medications from Tier 1 after the restructuring had the highest predicted probability of non-VA pharmacy use from regression analyses. Among respondents subject to VA copayments, 27% reported being better able to afford medications after the restructuring. However, 29% reported worrying about paying for medications, and 18% reported making tradeoffs (e.g., spending less on utilities, food) to pay for prescriptions.

Association Between the Patient-Driven Payment Model and Therapy Use, Patient Outcomes, SNF Expenditures, and Postacute Care Use Among Skilled Nursing Facility Beneficiaries by Dual Eligibility.

WANG, X., *et al.*

2026

Medical Care Research and Review 83(1): 33-43.
https://doi.org/10.1177/10775587251381534

Medicare and Medicaid dual-eligible beneficiaries (i.e., dual eligibles) have complex care needs and often experience poor outcomes in skilled nursing facilities (SNFs). The newly implemented patient-driven payment model (PDPM) changed SNFs' postacute care delivery model and may differentially impact dual eligibles. This study describes the trend breaks due to the PDPM on therapy use, patient outcomes, SNF expenditures, and postacute care use, by dual eligibility status. We utilized health care administrative data and regression discontinuity analysis to examine the change in outcomes among 2 million SNF beneficiaries. We found that dual eligibles experienced greater increases in SNF expenditures than Medicare-only beneficiaries ($771.4 vs. $418.5). No meaningful differences were observed in the change in quality or postacute care use patterns. The increase in SNF expenditure could be due to upcoding or comorbidities not accounted for previously. Our results illustrate the heterogeneous effects of the PDPM.

Environnement et santé

Environmental Health

Empreinte carbone et adaptation des soins médicaux. Troisième partie : Santé planétaire et médecine générale

AUBERT, H. ET CHARLES, R.

2025

Médecine 21(9): 405-409.
https://doi.org/10.1684/med.2025.1142

L'empreinte carbone du secteur de la santé est évaluée à 4,4 %. Un premier article étudiait comment on mesure cette empreinte carbone en France et décrivait brièvement les effets du dérèglement climatique, mondialement néfastes pour la santé. Le deuxième article étudiait les principales causes d'émissions dans le système hospitalier, ainsi que différents moyens à mettre en œuvre afin de les minimiser. Ce troisième aborde les solutions d'adaptation en médecine générale, notamment via le concept de « santé planétaire ».

Greening healthcare through circular economy: advancing health and sustainability in policy and practice

OR, Z.

2026

European Journal of Public Health 36(Supplement_2): ii8-ii13.
https://doi.org/10.1093/eurpub/ckaf251

Through its activities and energy consumption, the healthcare sector contributes to environmental degradation and climate change. With rising healthcare demands, the adoption of sustainable models has become increasingly urgent. Circular economy (CE) principles—Reduce, Reuse, Recycle, and Recover—offer a strategic framework to minimize waste and resource use while enhancing system resilience. A narrative review was conducted using Medline (PubMed) and Web of Science, covering literature from January 2015 to June 2025. Studies were selected based on relevance to CE principles in healthcare, including case studies, reviews, and original research. The review identified diverse interventions aligned with CE principles, including reducing low-value care and energy consumption, optimizing surgical trays, promoting reusable medical devices, enhancing waste segregation, and recovering energy from non-recyclable waste. Case studies from various countries highlight both environmental and economic benefits, such as lower CO2 emissions, cost savings, and greater operational efficiency. However, challenges remain, including limited climate literacy, regulatory gaps, and insufficient leadership. Applying CE principles in healthcare can significantly reduce environmental impact while supporting high-value care and financial sustainability. Broader adoption requires systemic policy support, stakeholder engagement, and integration of environmental metrics into clinical and procurement decisions.

État de santé

Health Status

Potential and challenges for sustainable progress in human longevity

BONNET, F., *et al.*

2026

Nature Communications 17(1): 996.
https://doi.org/10.1038/s41467-026-68828-z

Decelerating gains in life expectancy (e0) in high-income countries have raised concerns about the future of human longevity. To enhance our understanding of these developments, we examine subnational (N = 450) mortality trends in Western Europe in the period 1992-2019. Between 1992 and 2005, gains in life expectancy were both substantial and widespread. Laggard regions experienced the fastest improvements, yielding rapid regional convergence. Between 2005 and 2019, however, gains in these regions decelerated, while remaining remarkably stable in vanguard regions, suggesting that it remains possible to continue extending longevity. The observed slowing of e0 gains is strongly associated with mortality at ages 55-74, which increased in this period across large areas of Western Europe, particularly in Germany and France. In this work, we show that monitoring mortality trends at a fine geographical level is crucial for revealing both the potential for, and challenges to, sustainable progress in human longevity.

Obesity, sedentary behavior and lifestyle: A lifecycle model of eating and physical activity

DRAGONE, D., FEICHTINGER, G., GRASS, D., *et al.*

2026

Journal of Health Economics 106: 103114.
https://doi.org/10.1016/j.jhealeco.2026.103114

We propose a theoretical model to study individual lifestyle choices related to calorie intake and physical activity, depending on personal fitness and body weight. The model builds on the rational eating literature and can generate a variety of behaviors that are consistent with the empirical evidence. In particular, we show that engaging in periods of a sedentary lifestyle can be a rational, utility-maximizing decision—a finding that is not present in the existing literature but is empirically widespread. Additionally, we show the possible existence of multiple equilibria and multiple indifferent lifestyles. The former justifies policy interventions to help individuals exit a self-reinforcing, but unhealthy equilibrium; the latter provides a theoretical basis for remediation plans that compensate for earlier unhealthy behaviors.

Multiple social positions and well-being among Nordic adolescents: An intersectional MAIHDA analysis of the interplay between gender, age, immigrant background, family structure, and perceived socioeconomic status

GUSTAFSSON, J., *et al.*

2026

Social Science & Medicine 389: 118805.
https://doi.org/10.1016/j.socscimed.2025.118805

Background Research on well-being inequalities has typically examined the independent effects of social positions, often overlooking how the interplay of multiple social categorizations can shape well-being outcomes. This study explored how multiple social positions based on gender, age, immigrant background, family structure, and perceived family socioeconomic status shape patterns of inequality in three well-being outcomes—psychosomatic complaints, mental well-being, and problematic social media use—among Nordic adolescents. Methods Data from the Health Behaviour in School-aged Children Study, collected in four Nordic countries (Finland, Iceland, Norway, and Sweden) in 2022 (N = 22 366, ages 9–19), were analyzed using the Multilevel Analysis of Individual Heterogeneity and Discriminatory Accuracy (MAIHDA) approach. Participants were nested within 168 strata defined by their multiple social positions. Results Of the additive contributions of individual social positions, female gender was most strongly associated with poorer well-being across all outcomes. Interaction effects indicating more favorable well-being than expected based on additive main effects were identified across all outcomes for non-immigrant girls aged 9 to 12 perceiving high family socioeconomic status. Unexpectedly, non-immigrant boys aged 15 years and older from nuclear families with low perceived family socioeconomic status reported better well-being levels than anticipated. In contrast, interaction effects demonstrating less favorable well-being were observed for older, non-immigrant girls from nuclear families with high perceived family socioeconomic status, who reported poorer outcomes than expected. Several other subgroups also displayed significant deviations from anticipated outcomes in specific well-being domains. Conclusions The findings reveal significant intersectional disparities in well-being, notably in psychosomatic complaints and problematic social media use. The same social positions can form different patterns of advantage and disadvantage for individuals across different subgroups.

Utilizing a Health Equity Framework to Explore Patient-Level Factors Impacting Effective Hypertension Management Across Two Academic Health Systems

KRAMER, J., *et al.*

2026

Medical Care Research and Review 83(2): 144-155.
https://doi.org/10.1177/10775587251391490

Social determinants of health contribute to disparities in cardiovascular outcomes, including hypertension. This study utilized a health equity framework to assess patient-level factors influencing hypertension management across two health systems in North Carolina and Kansas. We interviewed 29 providers and 25 patients with hypertension from 14 clinics, including 13 primary care clinics—6 high-performing, 1 mid-performing, and 6 low-performing—and 1 cardiology clinic. Thematic analysis and open coding methodologies were used during analysis. Five salient patient-level themes emerged: patient resources, health literacy, lifestyle, intentionality, and patient-centered care. All providers identified health literacy as a critical barrier; however, those in low-performing clinics more regularly cited literacy-related challenges, with some associating patients' rurality with decreased understanding and intentionality. Mental health was also linked to hypertension management, as anxiety may exacerbate symptoms, while depression can reduce treatment motivation. Our findings underscore the need for individualized, equity-informed hypertension management strategies.

Corrigendum to "Adventurous play for a healthy childhood: Facilitators and barriers identified by parents in Britain" [Soc. Sci. Med. Volume 323, April 2023, 115828]

OLIVER, B. E., *et al.*

2025

Social Science & Medicine: 118403.
https://doi.org/10.1016/j.socscimed.2025.118403

The impact of incarceration on health: A global systematic review

PEARCE, L. A., *et al.*

2026

Social Science & Medicine 393: 118946.
https://doi.org/10.1016/j.socscimed.2026.118946

Health outcomes for people released from incarceration are often poor, but it is unclear to what extent these poor outcomes are a result of incarceration or are a consequence of pre-existing morbidity and health risk. We synthesised published evidence regarding the impact of incarceration on physical and mental health. We searched five electronic databases (PsycINFO, CINAHL Complete, Medline, EMBASE, and Campbell Collaboration) for primary research articles measuring at least one health outcome both before and after an episode of incarceration. We screened articles published in any country and placed no restrictions on publication date. We assessed risk of bias using the MethodologicAl STandards for Epidemiological Research (MASTER) scale and conducted a narrative synthesis. Nine studies met the inclusion criteria, seven of which were from the United States. Compared to pre-incarceration, post-incarceration health measures generally indicated reduced substance dependence and increased HIV viral suppression. Changes in mental health-related measures after incarceration were mixed: one study reported an increase in depressive symptoms and another study reported no change in the prevalence of depression, anxiety, psychotic disorders, or personality disorders. The prevalence of physical health conditions did not change substantially from before to after incarceration. The evidence base is sparse, lacks global representation, and is unable to assess causality. Nevertheless, our synthesis of the available evidence suggests that incarceration is associated with both positive and negative health outcomes. Further rigorous and longitudinal research is required, in diverse countries and world regions, to enable causal inference and identify modifiable factors that mediate the impacts of incarceration on specific health outcomes.

Individual and environmental stressors in life course cognitive health disparities: Evidence from the Dutch Lifelines Cohort Study

SOARES, M., *et al.*

2026

Social Science & Medicine 391: 118884.
https://doi.org/10.1016/j.socscimed.2025.118884

We examine the age and socio-economic gradients in cognitive health and explore how both relate to environmental, health-behavioural, and psychosocial factors. We use data from the Lifelines Cohort Study, which includes two measures of cognitive health, as well as individual education, household income, and neighbourhood socio-economic status (NSES) scores as indicators of socio-economic position, comprising 109,669 individuals aged 18 to 91 years. Our analysis reveals that cognitive health declines non-linearly with age. While accounting for this pattern, we also find a clear socio-economic gradient; a higher socio-economic position is associated with better cognitive health. Moving beyond both gradients, we show that, large differences between individuals remain, which are related to environmental, health-behavioural, and psychosocial factors. We decompose this persisting variation in cognitive scores into different components using a Shapley decomposition. We find that age and education have the highest explanatory power. Nonetheless, environmental factors become increasingly more important as individuals get older, in some cases matching or even surpassing education in explanatory power.

Adolescence in social context: Longitudinal associations of 15 social factors with health and well-being

WILKINSON, R., *et al.*

2026

Social Science & Medicine 394: 118993.
https://doi.org/10.1016/j.socscimed.2026.118993

Concern is growing that social disconnection poses serious risks to health and well-being, especially for adolescents. Yet without clear evidence on which relational factors (e.g., parent-child, sibling, romantic, and friend relationships; connectedness to families, schools, and neighborhoods) matter most, designing effective, developmentally attuned interventions remains difficult. To address this question, we used data from a large, nationally representative sample of U.S. adolescents (Add Health) and an outcome-wide approach to prospectively test whether one-year changes (between Wave I: 1994–1995 and Wave II: 1996) in 15 social factors, spanning structural, functional, and quality domains, were associated with 34 indicators of health and well-being 11.37 years later (in Wave IV: 2008, N = 11,040) or 20.64 years later (in Wave V: 2016–2018, N = 9003), adjusting for an extensive set of covariates. The outcome-wide framework fits a series of regression models for the relationship between one predictor and a set of outcomes (one outcome analyzed at a time), adjusting for the same set of covariates in each regression model. Six factors (school connectedness, loneliness, emotional support,

neighborhood cohesion, religious service attendance, and family cohesion) showed associations with at least one-quarter of outcomes. Associations were most consistent in psychological well-being, mental health, and civic/prosocial domains. Strengthening school connectedness and emotional support, and reducing loneliness, appear especially promising for fostering long-term health.

Géographie de la santé

Geography of Health

Cognability across adulthood: A qualitative investigation of neighborhoods and cognitive health behaviors

FINLAY, J., *et al.*
2026
Social Science & Medicine 392: 118971.
https://doi.org/10.1016/j.socscimed.2026.118971

While geographic variation in Alzheimer's Disease and Related Dementias (ADRD) rates suggests that environmental factors are important in the development of dementia, understanding of specific neighborhood sites that impact dementia risk is limited, especially in early and mid adulthood. This paper extends Cognability to a life course perspective to conceptualize how neighborhoods may support cognitive health behaviors including physical activity, diet, cognitive stimulation, and socialization across adulthood. The Neighborhoods and Health at All Ages Study employed stationary and mobile interviews (August 2023–March 2024) across the Minneapolis-St. Paul (MN) metropolitan area. Participants were on average 42 years old (range: 23–75). About half (53 %) identified as female, 40 % male, and 7 % nonbinary. Participants reflected diverse racial and ethnic backgrounds, including Asian (22 %), Hispanic (22 %), non-Hispanic White (18 %), Multiracial (17 %), Black/African American (15 %), American Indian/Alaska Native (3 %), and Other/Missing (3 %). Reflexive thematic analysis identified ten neighborhood services and amenities that support cognitive health behaviors: parks and paths, recreation centers, eateries, grocers and food markets, retail stores, civic and social organizations, religious organizations, arts and cultural sites, libraries, and educational sites. The study captured nuanced, intersectional perspectives from adults with varied socioeconomic, racial/ethnic, and gender identities to illuminate how use and salience of neighborhood services and amenities vary across adulthood. As the global dementia burden grows and disparities widen, our results help inform upstream community-level interventions to create more equitable neighborhoods that reduce ADRD risk and support lifelong cognitive health and wellbeing.

Geographic access to lung cancer screening and environmental lung cancer risk factors in the contiguous United States

ANYANWU, C., *et al.*
2026
Health & Place 97: 103588.
https://doi.org/10.1016/j.healthplace.2025.103588

Objective Lung cancer is the leading cause of cancer mortality in the U.S., and worldwide. We examined the association between geographic access to lung cancer screening facilities (LCSF) and geographically distributed lung cancer risk factors – fine particulate matter (PM2.5) and indoor radon levels in the contiguous U.S. Methods We estimated geographic access to LCSF using facility information from the American College of Radiology, Lung Cancer Screening Registry and the enhanced two-step floating catchment area method. Census tract level PM2.5 and county level radon data were obtained from the U.S. EPA. We examined whether PM2.5 and radon predicted geographic access to LCSF using a linear mixed effects model with random intercepts for counties, adjusting for smoking prevalence and other factors, and testing for modification by urban-rural area. Results We found higher geographic access to LCSF in counties with moderate and high radon levels, and census tracts with higher levels of PM2.5, with significant modification by urban-rural areas. Discussion Our results suggest that accessibility to LCSF in the U.S. is generally aligned with environmental risk factors for lung cancer, with the

exception of micropolitan areas or small cities, where higher PM2.5 areas had lower screening access. It is worth considering how environmental risk factors may be incorporated into lung cancer screening programs.

Area-socioeconomic disadvantage and cognitive function among Chinese older adults: the mediating role of healthcare resources and the moderating role of individual socioeconomic status

JIANG, X., *et al.*

2026

Social Science & Medicine 392: 118987.

https://doi.org/10.1016/j.socscimed.2026.118987

Objectives This study examines how city-level socioeconomic status (SES) is associated with cognitive function among older adults in China, and explores the mediating role of healthcare resources and the moderating role of individual SES in this context. Methods We relied on data from the 2018 wave of the China Health and Retirement Longitudinal Study, which provided individual cognitive function and demographic characteristics. Area-level SES and healthcare resource indicators were obtained from national statistical sources. A total of 9520 individuals aged 60 years or older from 123 cities were included in the analysis. A multilevel moderated mediation model was applied, and subgroup analyses by gender were conducted. Results Both individual- and area-level SES were positively associated with cognitive function. Multilevel mediation models of healthcare resources showed that only physician density (i.e., not hospital or bed supply) partially mediated the association between area-level SES and cognitive function. After individual SES was introduced as a moderator, the cognitive benefits of healthcare human resources were greater for low-SES individuals than for high-SES individuals. However, evidence for this moderating effect was not consistently supported across variations in sample composition and cognitive measurement. Gender-stratified analyses further showed no clear evidence supporting an individual-SES-based moderating effect in either men or women. Conclusion Our findings emphasize the fact that area-level SES and healthcare human resources shape late-life cognition, suggesting equity-focused policies that address structural disadvantage to reduce disparities in cognitive aging.

How do counties' industrial structures shape geographic disparities in cardiovascular disease mortality?

SUN, Y. ET ESPOSITO, M. H.

2026

Social Science & Medicine 392: 118960.

https://doi.org/10.1016/j.socscimed.2026.118960

Industrial structures refer to the employment opportunities provided by different industries. When employment is concentrated in a single industry, that industry can capitalize power, reshaping political economic logic and, by extension, social life. In this study, we theorize industrial structure as a political determinant of health and investigate the causal pathways linking these configurations to mortalities from cardiovascular disease (CVD). Using county-level data and counterfactual-based causal mediation analysis, we find that CVD mortality rates are significantly higher in counties with heavy dependencies on production and extraction industries, such as manufacturing and mining. While the specific mediating mechanisms vary by industry, we find that an uneven distribution and transformed impact of economic opportunities helps to explain these county-to-county inequalities in premature death. Altogether, these findings suggest industrial structures are an important structural determinant of health and illuminate the causal pathways linking these structures to health outcomes.

The impact of place on health: Neighbourhood & residential satisfaction as a contributor to physical and mental health in applicants for publicly subsidized housing

TAYLOR, N. C., WOODHALL-MELNIK, J., LAMONT, A., *et al.*

2026

Health & Place 98: 103641.

https://doi.org/10.1016/j.healthplace.2026.103641

Little is known about residential satisfaction in individuals who wait for subsidized housing and its relationship to health. This paper measures residential satisfaction in applicants for subsidized housing in New Brunswick, Canada and investigates its contributions to mental and physical health. The findings indicate that residential dissatisfaction is significantly associated with depression and distress; however, it is not significantly associated with physical health. The authors conclude that individuals may experience

better mental health with the introduction of targeted interventions (e.g. programs to improve social interactions in lower income neighbourhoods) to improve residential dissatisfaction.

Handicap

Disability

▶ Digital Health: An Opportunity to Advance Health Equity for People With Disabilities

JAIN, P., *et al.*

2025

Milbank Q 103(4): 966-987.

https://doi.org/10.1111/1468-0009.70049

Policy Points Universal Design and Inclusion: Mandate all digital health platforms, devices, and services be built on universal design principles and codeveloped with people with disabilities, ensuring compatibility with assistive technology and emergency response features. Standardized Disability Data Collection: Implement mandatory, standardized disability data collection in electronic health records with robust privacy protections, addressing the Patient Protection and Affordable Care Act Section 4302 gaps while enabling personalized care and research. Accessibility as Civil Rights: Treat accessibility as a civil rights issue with strict enforcement of Section 508, Americans With Disabilities Act, and Section 1557, including the patient interoperability mandate, penalties for noncompliance, and legal recourse for patients. Funding and Incentives: Establish funding incentives prioritizing disability equity, digital literacy programs, value-based payment models, and workforce training for healthcare professionals using disability-inclusive digital health tools.

▶ The Impact of Enhancing Social Care on Healthcare Use for People With Disability: Evidence From Australia

MA, B. H., *et al.*

2026

Health Economics 35(2): 212-228.

https://doi.org/10.1002/hec.70055

ABSTRACT This study examines the impact of enhanced social care provided through the Australian National Disability Insurance Scheme (NDIS) on subsidized healthcare utilisation for people with disability. Using linked administrative datasets from 2011 to 2020, we employed a Difference-in-Difference model and the staggered rollout of the NDIS to assess its effects on healthcare services, focusing on visits to general practitioners (GP), mental healthcare providers, allied health professionals, specialists, and mental health prescriptions. The results show that the NDIS reduced subsidized mental health services and allied health services in the six quarters after enrollment. However, it did not significantly affect visits to GP, specialists, or mental health prescriptions. These effects were most pronounced among individuals aged 0–24 years, males, and those living in major cities. The findings suggest that services available from NDIS may substitute for subsidized healthcare services by providing non-clinical care through social care channels. Further research is needed to investigate the long-term effects and health outcomes of the NDIS.

▶ The Impact of Functional Limitation Status on All-Cause and Premature Mortality Among US Adults: Findings from the 2011 National Health Interview Survey

ORLOV, D., *et al.*

2025

Disability and Health Journal: 102018.

https://doi.org/10.1016/j.dhjo.2025.102018

ABSTRACT Background Functional limitation (FL) encompasses impaired performance across six physical and cognitive health domains. While the impact of FL on health outcomes is recognized, its longitudinal association with survivorship in United States (US) adults remains underexplored. Objective Using the National Health Interview Survey 2011 (NHIS 2011) and the associated 2019 Linked Mortality File (LMF 2019), this survival analysis evaluates whether US adults who report experiencing FLs are at a greater risk of

all-cause and premature mortality compared to adults who do not report any FLs. Methods We categorized respondents (n=15,958) into three FL groups (no difficulty, some difficulty, a lot of difficulty) and employed survey-weighted Cox regression models to estimate hazard ratios (HRs) for mortality outcomes, adjusting sequentially for demographic, socioeconomic, and health-related variables. Results At baseline, 35.7% of participants reported at least some FL, and 10.2% reported a lot of FL. Those with a lot of FL faced higher risks for all-cause mortality (adjusted Hazard Ratio (aHR)=3.24; 95% Confidence Interval (CI): 2.71–3.87) and premature mortality (aHR=2.79; 95% CI: 1.83–4.26) in the fully-adjusted models. These associations attenuated through sequential adjustment, suggesting confounding by sociodemographic and health-related factors. Conclusion Though the FL-mortality link weakens after adjusting for sociodemographic and health factors, FL remains a key marker of vulnerability, especially in older adults with multimorbidity. Future research should explore the impact of FLs on cause-specific mortality and closely examine which of the six domains of functionality are independently related to survivorship.

Hôpital

Hospital

Time to Spare and Too Much Care? Crowding, Medical Intervention and Health Outcomes in the Maternity Ward

BENSNES, S.

2026

Health Econ 35(2): 175-211.

https://doi.org/10.1002/hec.70048

This paper examines the causal effect of crowding in maternity wards on medical treatment and health outcomes. To address endogeneity concerns, I focus on mothers and their newborns in Norwegian maternity wards and use the number of women with the same due date in a local area as an instrument for crowding. Using detailed administrative data covering all births in Norway over multiple years, I find that crowding-measured as a higher admission level-causes fewer unplanned readmissions and improved APGAR scores. On crowded days, mothers receive fewer inductions and other medical interventions, and no corresponding increase in reported complications. The instrumental variable strategy addresses potential endogeneity biases inherent in fixed-effects models and yields qualitatively similar estimates.

Hospitals in Some States Under Report Medicaid Discharge Counts in Cost Report Data

CHALMERS, K., *et al.*

2026

Health Services Research 61(1): e70043.

https://doi.org/10.1111/1475-6773.70043

ABSTRACT Objective To investigate discrepancies in Medicaid enrollees' hospital discharges reported in two data sources widely used in health services research: the CMS Hospital Cost Report Information System (HCRIS) and the T-MSIS Analytic Files (TAF). Study Setting and Design This is a descriptive study comparing inpatient discharges reported in the two data sets. We included inpatient admissions at general hospitals in 2020–2021.Data Sources and Analytic Sample We used HCRIS data covering reporting periods starting in 2020 and ending sometime in 2021 (this varied by hospital) and extracted the reported total and Health Maintenance Organization (HMO) funded Medicaid discharges and patient days. We used the 2020 and 2021 TAF inpatient files and included inpatient admissions within each hospital's HCRIS reporting period, and calculated discharges for each hospital. Principal Findings There were 25 states where some hospitals had higher TAF discharge counts than HCRIS, and these same hospitals had inconsistent reporting of HMO-funded Medicaid discharges and patient days in HCRIS. This included California, New York, and Texas. There were 20 states with similar values reported in

both HCRIS and TAF, and 9 of these were in states with < 5% of their enrolled Medicaid population in a comprehensive managed care plan. Conclusions The discrepancies between HCRIS and TAF data indicate that HCRIS may not reliably capture hospital discharge volumes for Medicaid patients, particularly those funded by managed care. These inconsistencies can misinform policy decisions and evaluations of hospital performance. Policymakers and researchers should exercise caution when using HCRIS data for Medicaid discharge counts and consider supplementing it with TAF or other sources.

Influence of Admitting Clinician on Outcomes in Post-Acute Facilities

CHEN, A. C. ET MCWILLIAMS, J. M.

2026

Health Services Research 61(1): e70017.

https://doi.org/10.1111/1475-6773.70017

ABSTRACT Objective To compare outcomes between patients admitted to different clinicians within skilled nursing facilities for post-acute care, leveraging the plausibly random distribution of patients to admitting clinicians in the case of clinicians who specialize in nursing facility care (SNFists). We also compare patient outcomes between SNFists who are physicians versus advanced practice providers (APPs). Study Setting and Design We used multi-level modeling to estimate within-SNF variation in the characteristics and outcomes of patients admitted to different SNFists and linear regression to compare patient characteristics and outcomes between physician and APP SNFists. Our main outcomes were 30-day hospitalizations, 30-day mortality, and antipsychotic use. Data Sources and Analytic Sample We analyzed claims data for a 20% sample of traditional Medicare beneficiaries admitted to a SNF for post-acute care from 2016 to 2019. Principal Findings The sample included 81,789 post-acute patients seen by 6273 SNFists at 1479 facilities between 2016 and 2019. Within-facility variation in patient characteristics across admitting SNFists was modest and substantially greater across admitting clinicians who were not SNFists, consistent with our key assumption that patients are distributed in a more balanced fashion across admitting clinicians who are SNFists. With patient-level confounding limited by this focus on SNFists, there was minimal to modest variation in the rates of mortality (adjusted standard deviation: −0.14), hospitalization (0.40), and antipsychotic use (1.10) across admitting clinicians. Outcomes also did not differ between APP and physician admitting SNFists (mortality: 0.001 [95% CI: −0.001, 0.003]; hospitalization: 0.004 [95% CI: −0.001, 0.010], antipsychotic use: −0.001 [95% CI: −0.006, 0.003]). In contrast, outcomes varied substantially across admitting clinicians who were not SNFists. Conclusions Quasi-experimental assignment of patients to clinicians in SNFs reveals that the admitting clinician appears to have little influence on key outcomes in the post-acute setting, in contrast with similar research conducted in other care settings. An analysis of non-SNFists might falsely conclude that the impact of clinician factors is large because of evident non-random sorting of patients to non-SNFist clinicians in SNFs.

Inpatient to Outpatient Shifts in Surgical Care: Persistence of COVID-19 Era Changes and Socioeconomic Variations

CHEN, A. T., *et al.*

2026

Medical Care Research and Review 83(2): 156-164.

https://doi.org/10.1177/10775587251396718

The COVID-19 pandemic disrupted surgical care delivery, yet the extent to which shifts from inpatient to outpatient settings have persisted remains unclear. Using medical claims data from Independence Blue Cross (2018–2022), we examined changes in surgery settings across 102 procedures before the pandemic and during the 2 years following the suspension of elective surgeries. After 2 years, inpatient volumes decreased for 9 of the 20 most common pre-pandemic inpatient procedures, with corresponding increases in outpatient utilization. Hip and knee replacements experienced the most pronounced shifts, with inpatient shares falling by more than 40 percentage points. Patients from lower-income census tracts saw greater declines in overall procedure volumes (−6.0%) compared to those from higher-income areas (+5.2%). Total allowed amounts decreased for procedures with outpatient migration, while out-of-pocket costs remained stable. These findings suggest durable, post-pandemic shifts in surgical care delivery patterns, with potential implications for access, costs, and equity.

Maternity Ward Closures and Infant Health Outcomes, Maternal Health Outcomes, and Birth Procedures

DE LINDE, A., *et al.*

2026

Health Economics 35(2): 360-376.

https://doi.org/10.1002/hec.70053

ABSTRACT We analyze the short- and long-term impacts of maternity ward closures using registry data on every delivery in Norway from 1981 through 2019. Among those directly experiencing a closure, we find a small decline in 5-minute Apgar score and increased probability of birth outside institution. Since this drop in Apgar is not reflected across the other indicators, we hypothesize it reflects different institutional scoring standards as opposed to a health effect. For long-term outcomes, we find treatment as an infant increases the likelihood of beginning high school by 1 percentage point, but has no effect on graduating. Furthermore, for infants assigned female at birth, we find early-life treatment does not change the probability of giving birth as an adult or experiencing negative health conditions during pregnancy. We hypothesize robust prenatal care and health and social services may mitigate the impact of closures and thus account for a limited treatment effect.

Quality of Care, Hospital Bypass, and Follow-Up Visits Following an ED Visit for Rural Heart Failure Patients

FRIEDMAN, H. R., *et al.*

2026

Health Services Research 61(2): 1-12

https://doi.org/10.1111/1475-6773.70079

ABSTRACT Objective To determine if hospital bypass (use of the non-closest hospital) and/or hospital quality are associated with the probability of a patient receiving a timely follow-up visit following discharge from an Emergency Department (ED) visit for heart failure. Study Setting and Design Our sample consisted of all ED visits for heart failure in a population of Medicare beneficiaries. Our outcome was an outpatient visit within 7 days of discharge. Our primary independent variables consisted of an indicator of hospital bypass and four hospital quality measures: Overall Star Rating, Hospital Consumer Assessment of Health Providers and Services (HCAHPS) Summary Star Rating, Hospital-Wide Readmission Rate, and Heart Failure Readmission Rate. We used propensity score weighted-logistic regression models to predict the probability of follow-up within 7 days. Propensity score weighting accounted for clinical and demographic differences between those who bypassed and those who did not. Separate models were generated for each quality measure. Data Sources and Analytic Sample We used data from a 2015–2019 20% Sample of Medicare Fee-for-Service claims, hospital quality measures from the Centers for Medicare and Medicaid Services' Hospital Compare, and data from the Healthcare Cost Reporting Information System. Principal Findings76,949 visits met the eligibility criteria. We found that patients who used the nearest hospital were more likely to have a follow-up visit than those who bypassed (average marginal effect [AME]: 0.010, $p < 0.05$). Better performance on each quality measure was also associated with a higher probability of follow-up, with HCAHPS having the strongest (AME: 0.015, $p < 0.001$) association. Conclusions Using the nearest hospital (i.e., not bypassing it) and using higher quality hospitals was associated with a higher probability of timely follow-up, which may be important in preventing hospital readmissions. There may be benefits to rural patients' use of their nearest hospital, such as proximity to support and lower travel burden.

Risk of Hospital Readmissions and Association With Receipt of Post-Hospitalization Care Coordination Services Among High-Risk Veterans

GOVIER, D. J., *et al.*

2026

Health Services Research 61(1): e70044.

https://doi.org/10.1111/1475-6773.70044

ABSTRACT Objective To examine associations between receipt of post-hospitalization care coordination and VA-delivered, VA-purchased, and Medicare fee-for-service hospital readmissions among Veterans at high risk for hospitalization and/or mortality. Study Setting and Design In this observational retrospective cohort study, we compared high-risk Veterans who received care coordination within one day after hospital discharge ("treated") with up to five matched high-risk Veterans who did not receive care coordination during this time ("comparators"). Competing risk models estimated adjusted sub-hazard ratios (aSHR) for 30-day all-cause and ambulatory care sensitive condition (ACSC) readmissions between treated and comparators, with death as a competing risk. In sensitivity analyses, we implemented inverse probability of censoring weights to account for censoring due to cross-over to treatment

among comparators during follow-up. Data Sources and Analytic Sample Data sources included the VA Vital Status File, VA Corporate Data Warehouse, and Centers for Medicare and Medicaid Services administrative files. Participants included 31,614 treated and 99,634 comparator high-risk Veterans initially hospitalized in fiscal year 2021.Principal Findings Participants were primarily male sex, ≥ 65 years of age, and had initial hospitalizations in VA facilities; 15.9% and 2.3% of treated Veterans had 30-day all-cause and ACSC readmissions, respectively, compared with 13.5% and 2.1% of comparators. After accounting for the competing risk of death and covariates that remained imbalanced across groups after matching, post-hospitalization care coordination was associated with no difference in the risk of 30-day all-cause (aSHR 1.03, 95% CI 1.00, 1.07) and ACSC (aSHR 0.97, 95% CI 0.89, 1.05) readmission among high-risk Veterans. The risk of ACSC readmission was similar after including censoring weights (aSHR 1.00, 95% CI 0.92, 1.09); the increased risk of all-cause readmission was small in magnitude but statistically significant (aSHR 1.09, 95% CI 1.05, 1.13).Conclusions Receipt of post-hospitalization care coordination was largely associated with no difference in 30-day readmission risk, suggesting that alternative or additional services may be needed to address readmissions among high-risk Veterans.

Mass Medical Evacuations to Decrease the Intensive Care Burden: Results From the TRANSCOV Cohort Study

GRIMAUD, O., *et al.*

2026

CHEST. 169 (2) : 390-400

https://doi.org/10.1016/j.chest.2025.08.023

BACKGROUND: In a context of overwhelming demand, mass transfers between ICUs were organized in France during the first COVID-19 epidemic wave (spring 2020). According to early reports, transferred patients experienced a 3- to 4-fold lower ICU case fatality. It is not known whether this difference stems only from the selection of healthier patients for transfer. RESEARCH QUESTION: Is the 28-day ICU case fatality of transferred patients different from that of matched control (not transferred) patients? STUDY DESIGN AND METHODS: This was a multicenter retrospective cohort study that included 285 transferred patients and 667 control (not transferred) patients admitted simultaneously (+/- 2 days) to the same origin ICU and were alive 5 days after the transfer date. The 28-day ICU case fatality and clinical events during ICU stay were compared in transferred and control patients. RESULTS: At ICU admission, age, COVID-19 severity, comorbidities, and Simplified Acute Physiology Score II were similar, but transferred patients were lighter (81 vs 89 kg, P < .0001) and more autonomous than the matched control patients (64.5% vs 55.0%, P = .01). Case fatality was approximately 7-fold lower in transferred patients (adjusted incidence rate ratio, 0.14; 95% CI, 0.10-0.19). ICU stay was longer and delirium, psychiatric disorders, and neuromuscular blockade exposure were more frequent in transferred patients than control patients. Conversely, acute kidney injury was more frequent in control patients (51.5% vs 37.7%, P < .0001). INTERPRETATION: Although the selection of healthier patients likely contributed to better survival, removal from an overcrowded care environment probably also explains the large survival benefit associated with transfer. By reducing workload, mass transfers might have also benefited patients who remained in origin ICUs. Organizing mass transfers as early as possible may be an appropriate strategy for mitigating the impact of an overwhelming intensive care demand.

Prendre le virage de l'ambulatoire, à quel prix : L'exemple des chimiothérapies anticancéreuses injectables à domicile

MANUELLO, P. ET SICOT, F.

2025

Revue française des affaires sociales 2025(3): 268-283.

Considérée comme bonne pour les patients et les finances publiques, l'orientation des patients en hospitalisation à domicile (HAD) pour la réalisation de chimiothérapies anticancéreuses est jugée insuffisante par les pouvoirs publics qui en font la promotion. Comment l'expliquer ? Quelles sont les raisons avancées par les prescripteurs pour choisir ou non cette modalité de prise en charge ? L'article montre que les médecins ont largement adopté le calcul coûts/avantages de leurs pratiques mais qu'ils restent guidés par la prudence. En outre, malgré l'intérêt qu'il y aurait à externaliser des prises en charge pour libérer des places en hôpital de jour, des contraintes s'exercent qui entrainent pourtant le maintien des patients à l'hôpital. L'article illustre enfin le décalage qu'il peut y avoir entre la conception d'une politique publique de santé – ici développer l'ambulatoire via la HAD – et les conditions de sa mise en œuvre par les professionnels.

Seeking evidence of intersectional effects in emergency hospital readmissions of adults in England (2016–2019)

SPENCER, J., *et al.*

2026

Social Science & Medicine 390: 118773.

https://doi.org/10.1016/j.socscimed.2025.118773

Background Using a large administrative dataset, we explore intersectional effects in the risk of unplanned readmission after hospital discharge in England. We test whether the size and direction of these effects aligns with societal power dynamics that underpin theories of intersectionality. Methods We use logistic regression to explore the risk amongst adults in England, of an unplanned readmission within 30 days of discharge from hospital between 2016 and 2019. The model covariates include the patient's age, sex, ethnicity, socio-economic deprivation, morbidity levels, admission method, prior hospital use and hospital provider. We use two-way interaction terms between (a) sex and ethnicity, (b) sex and socio-economic deprivation, and (c) ethnicity and socio-economic deprivation, to test for intersectional effects. We identify 10 intersections which would theoretically be associated with increased or decreased advantage. Findings Of the 10.8 million eligible patient admissions in our study population, 17.2 % were readmitted to hospital within 30 days of discharge. For 2 of the 10 two-way intersections that we tested, we found evidence of increased or decreased risk of readmission that aligned with theories of intersectionality. For 6 intersections, we found no evidence of effect, and in 2 intersections we found evidence of an effect at odds with our prior theory. Interpretation Whilst sex, ethnicity, and deprivation influence the risk of readmission, we found limited evidence that these factors combine to increase or decrease a patient's risk. Where evidence was found, the direction of these effects did not always align with widely accepted societal power dynamics.

Veterans' Behavioral Health Hospitalizations and Outcomes in VA Versus Non-VA Hospitals

VANNEMAN, M. E., *et al.*

2026

Health Services Research 61(1): e70013.

https://doi.org/10.1111/1475-6773.70013

ABSTRACT Objective To compare outcomes for Department of Veterans Affairs (VA) enrollees' behavioral health (BH) hospitalizations by source (VA-direct, VA-purchased community care (CC), Medicaid, Medicare, private insurance, and other payers). Study Setting and Design We conducted a retrospective, longitudinal study with VA enrollees from 2015 to 2017 to examine differences in BH hospitalization outcomes by source. We used generalized linear models with clustered standard errors to predict length of stay (LOS), cost, and 30-day readmission. Data Sources and Analytic Sample We studied 124,609 BH hospitalizations of 77,299 VA enrollees in 11 geographically diverse states. Principal Findings Predicted mean LOS (9.03 days, 95% CI 8.92–9.14 days; $p < 0.001$) and cost ($17,608, 95% CI $17,347–$17,870; $p < 0.001$) were highest for VA-direct hospitalizations, while the mean readmission rate was lowest for VA-direct hospitalizations (17.36%, 95% CI 17.03%–17.69%; $p < 0.001$). Average marginal effects for each non-VA hospitalization source were statistically significantly different from VA-direct hospitalizations ($p < 0.001$): between 2.13 and 2.90 days less for LOS, $11,141 to $12,144 less for cost, and 2.71% to 5.18% higher for readmission rate. Conclusions The majority of BH hospitalizations were in VA-direct care (56%), with 44% provided in locations outside VA hospitals: Medicare (19%), CC (7%), private insurance (7%), other payers (6%), and Medicaid (5%). There are tradeoffs between BH hospitalizations provided in VA-direct care (lowest readmission rate, highest LOS and costs) and other sources.

Inégalités de santé

Health Inequalities

An intersectional approach to understanding systolic blood pressure distribution in a large French study: a MAIHDA analysis

SILBERZAN, L., *et al.*

2026

Social Science & Medicine 394: 119054.

https://doi.org/10.1016/j.socscimed.2026.119054

Inequities in systolic blood pressure (SBP), a widely used biomarker, have been shown to be patterned by age, sex, and socioeconomic position, but few studies have investigated how they combine to result in differential SBP risk. This study brings new insights by simultaneously considering sex, age, education, as well as race/ethnicity - a dimension seldom investigated in French health studies- in an intersectional perspective. Using data from the CONSTANCES cohort (2012–2021) in the French general population, we applied intersectionality theory and multilevel analysis of individual heterogeneity and discriminatory accuracy (MAIHDA) to examine SBP levels among 150,739 adults, not under BP lowering treatment, nested within 126 intersectional strata. Our models revealed substantial heterogeneity in SBP across strata, mainly driven by age and sex additive main effects. Older age, male sex, lower education, and Subsaharan African (SSA) and Overseas France (DROMs) groups were associated with increased SBP. SSA and DROMs individuals with fewer years of formal education consistently exhibited among the highest SBP values within each sex-age combination. Although age explained most of the between-strata variance, 25-39-year-old SSA and DROMs with fewer years of formal education displayed higher SBP levels than some 40–59-year-old individuals from other ethnoracial backgrounds, suggesting a premature increase of SBP levels for these strata. Our results show that SBP varies according to socially structured experiences, to the disadvantage of marginalized social groups. They emphasize the need for more intersectionality-grounded research on a wider range of biomarkers, and advocate for a more systematic inclusion of racism as a major axis of oppression in health inequities studies.

Do the Poor Gain More? The Impact of Secondary-Care Expenditure on Health Inequality

ANAYA-MONTES, M., *et al.*

2026

Applied Health Economics and Health Policy 24(2): 309-324.

https://doi.org/10.1007/s40258-025-01016-0

Quasi-experimental studies of mortality variation and trends among large administrative areas of England in the 2000s and early 2010s have suggested that more deprived populations gain larger mortality benefits from marginal increases in public expenditure on secondary care.

Understanding the systems dynamics of neighborhood socioeconomic inequities in health in European cities: a causal loop diagram

CAIL, V., *et al.*

2026

Health & Place 97: 103595.

https://doi.org/10.1016/j.healthplace.2025.103595

Urban neighborhood inequities in health remain a persistent public health issue, despite many efforts to promote health equity. Given the complex nature of these inequities, a complex systems science approach is essential to identify and understand their underlying causes. In this study, a causal loop diagram (CLD) was developed to visualize the underlying mechanisms contributing to urban neighborhood inequities in self-assessed health. The CLD was based on the results from a scoping literature review and the input from an interdisciplinary group of researchers. Three overarching themes were identified: 1) Uneven power dynamic in decision-making, 2) Socioeconomic sorting through environmental factors, 3) Mutual reinforcement of social cohesion and the physical environment. The interplay of these themes demonstrates that addressing neighborhood inequities in health requires an integrated approach that is inclusive in the decision-making processes and empowers communities.

A Method for Comparing Health Inequality Impact Magnitudes, with an Illustration for Hypothetical Treatments of 1336 Diseases

COOKSON, R., *et al.*

2026

PharmacoEconomics 44(3): 317-328.
https://doi.org/10.1007/s40273-025-01583-z

We aimed to facilitate the comparison and communication of magnitudes of health inequality impact across interventions for different diseases, and to indicate the potential range of such impacts.

Neighborhood socioeconomic inequalities in healthcare costs: the role of lifestyle behaviors

DE BOER, W. I. J., *et al.*

2026

European Journal of Public Health 36(1): 5-11.
https://doi.org/10.1093/eurpub/ckaf252

Socioeconomic inequalities in healthcare costs are large, but the underlying behavioral mechanisms remain unclear. We examined how neighborhood socioeconomic status (NSES) and lifestyle behaviors—physical activity (PA), sport participation, smoking, and alcohol use—jointly relate to healthcare costs in the Netherlands. Using a population-wide ecological dataset of 6213 neighborhoods, we linked relative (i.e. age- and sex-standardized) healthcare costs with survey-based estimates of lifestyle behaviors. Linear regression models estimated the associations between lifestyle factors and relative healthcare costs, adjusting for demographic and urbanization characteristics. Additional models stratified by NSES decile assessed socioeconomic modification of lifestyle–cost associations. A strong socioeconomic gradient in relative healthcare costs was observed; the most deprived NSES decile having €1096 higher average costs than the most affluent decile. NSES alone explained over €300 of this inter-decile cost gap. Across all neighborhoods, each 1-percentage-point higher sport participation, PA adherence, and smoking prevalence were associated with cost changes of –€14.27 (95% CI –16.96 to –11.59), –€6.96 (95% CI –9.59 to –4.32), and +€22.06 (95% CI 17.96 to 26.16), respectively; alcohol use showed no association. Within-decile analyses revealed strong protective effects of sport in the most deprived neighborhoods (–€37.26, 95% CI –47.54 to –26.97) and consistent cost increases associated with smoking across all deciles. Lifestyle–cost associations differ markedly by socioeconomic context. Structured sport participation shows the greatest cost-saving potential in disadvantaged neighborhoods, while smoking remains the dominant cost driver nationwide. Addressing behavioral inequalities is key to narrowing socioeconomic disparities in healthcare expenditures.

Risk factors for unmet health care need: evidence from the large population-based Healthy Finland 2022-cohort

ELOVAINIO, M., *et al.*

2026

European Journal of Public Health 36(1): 64-70.
https://doi.org/10.1093/eurpub/ckaf217

There is a need to efficiently identify groups at risk of unmet health service needs. In response, we developed and evaluated the performance of a regression model to assess unmet health service needs in the Finnish population. The study population consisted of population-based Healthy Finland 2022-cohort participants (N = 18 442), aged 20–104. The primary outcome was self-reported unmet need for physician's or nurse's services. A total of 38 potential risk factors were evaluated. Statistical models were developed using bootstrap-enhanced LASSO regression (bolasso). Of the participants, 5875 (32%) were classified as experiencing unmet health care need. The C-index from the final model including 15 predictors from the best bolasso models varied between 0.73 and 0.76 and pooled C-index over the imputed data sets was 0.75 (95% CI 0.70–0.79). Fifteen factors—including health-related, socioeconomic variables, heavy alcohol use, experiences with health services, caregiving for others, and language group—were found to be strongly associated with an increased risk of unmet health care needs and may be a useful targets for preventing unmet health care need.

Gender disparities in healthcare access persist even in more equitable societies: A multilevel assessment across 29 countries

FAKKEL, M., *et al.*

2026

Health Policy 166: 105579.
https://doi.org/10.1016/j.healthpol.2026.105579

Background Gender disparities in healthcare access

remain widespread despite economic and medical progress. These disparities, influenced by both individual- and country-level factors, vary across global contexts. This study investigates gender disparities in healthcare access across 29 countries spanning six continents. Objective To examine how individual- and country-level characteristics interact to explain gender disparities in self-reported healthcare access. Methods This cross-sectional, multilevel study draws on primary survey data from 2781 participants (68.8% women; Mage= 50.2, SD = 15.5), collected in 2023 by an international academic consortium under the G20's Civil20 platform. The sample covered 29 countries across six continents, with participation being higher in high-income regions with better research infrastructure. Participants reported whether they lacked access to various healthcare services. We used multilevel logistic regression with random intercepts for country and interaction terms between gender and individual-level (e.g., gender, age, education) and country-level (e.g., relative healthcare spending, political gender equality, gender pay gap) predictors. Results Women reported poorer healthcare access than men in 24 of 29 countries, particularly around age 50. Disparities were not reduced by being higher educated, nor by greater national healthcare spending or female political representation. Unexpectedly, gender disparities were larger in countries with smaller gender pay gaps, due to improved male – but not female – access. Conclusions Reducing gender disparities in healthcare access requires policy efforts beyond financial investment, including age-specific interventions and addressing provider bias. Mid-life women may be a particularly underserved group. Policymakers should consider psychological and institutional barriers and implement targeted, scalable solutions that go beyond resource allocation.

Year 1 Impact of Offering Non-Emergency Medical Transportation on Care Utilization Among Low-Income and Disabled Beneficiaries in Medicare Advantage

IANNI, K. M., *et al.*

2026

Health Services Research 61(2): e70086.

https://doi.org/10.1111/1475-6773.70086

ABSTRACT Objective To examine the effects of offering non-emergency medical transportation (NEMT) on care utilization among low-income and disabled beneficiaries in Medicare Advantage (MA). Study Setting and Design We leveraged the 2019 expansion of ?primarily health related? benefits to study the impact of offering NEMT on enrollees' utilization of care. We used an event study model to compare changes in care for beneficiaries enrolled in plans that began offering a NEMT benefit in 2019 versus those in plans that did not. Data Sources and Analytic Sample We used MA plan benefit package, Medicare enrollment, and MA encounter data for years 2016?2019 to identify plans offering NEMT, low-income and disabled beneficiaries enrolled in these plans, and model covariates. Principal Findings Offering of NEMT was associated with little change in utilization. We found a statistically insignificant 1.4% increase in the probability of receiving an annual wellness visit (Coef. 0.006; 95% CI, ?0.007?0.018, p?=?0.371) and a 4.0% decrease in ambulance use days (Coef. ?0.012; 95% CI, ?0.033?0.010, p?=?0.290). We did not find evidence of statistically significant or economically meaningful changes in outpatient evaluation and management, procedure, imaging, and emergency room visits. Conclusions In the first year of NEMT benefit offerings by MA plans, we found no detectable evidence of associated changes in care utilization among low-income and disabled beneficiaries. Conclusions about the potential value of coverage for NEMT are limited by the short evaluation period and lack of data on NEMT benefit generosity and use.

Low socioeconomic status as a major risk factor for early-onset type 2 diabetes with limited lifestyle mediation: Cross-Sectional evidence from US and South Korean populations

LIU, S., *et al.*

2026

Social Science & Medicine 391: 118939.

https://doi.org/10.1016/j.socscimed.2026.118939

This study aimed to examine the association between socioeconomic status (SES) and early- and late-onset type 2 diabetes (T2D), evaluate the mediating role of a healthy lifestyle in these associations, and further explore the contribution of various risk factors to different types of T2D. This study analyzed data from US NHANES, and Korean KNHANES, encompassing 20,655 US, and 26,575 Korean adults. SES was categorised as high, middle, or low based on income, education, employment, and insurance. A healthy lifestyle score included nonsmoking, no heavy drinking, regular physical activity, and a high-quality diet. Early-

onset T2D was defined as diagnosis before age 40. In NHANES, early-onset T2D prevalence was 1.35 %, rising from 0.85 % (high SES) to 2.41 % (low SES); late-onset prevalence was 5.63 %, with similar SES gradients. Comparable patterns emerged in KNHANES. Low SES consistently increased the risk of early-onset T2D, with stronger associations observed compared to late-onset T2D. A healthy lifestyle only mediated the relationship between SES and late-onset T2D. In early-onset T2D, a healthy lifestyle did not have a significant protective effect. The strength of the associations between the risk factors for early-onset T2D was generally greater than that for late-onset T2D, especially for obesity and family history of diabetes. Low SES is a stronger risk factor for early-onset T2D, with lifestyle interventions proving insufficient to mitigate risk. Public health efforts should prioritize addressing social determinants, early screening, and targeted education for vulnerable youth, particularly those with low SES, obesity, or a family history of diabetes.

▶ Socioeconomic advantage as protection from genetic mental health risks

MARTIN-BASSOLS, N., *et al.*

2026

Social Science & Medicine 391: 118845.

https://doi.org/10.1016/j.socscimed.2025.118845

The burden of mental illness is unequally distributed, with higher prevalence among socioeconomically disadvantaged individuals and those with a genetic predisposition to mental illness. Using data from the U.S. Health and Retirement Study (HRS), we examine whether childhood socioeconomic status (SES) moderates the association between genetic predisposition — measured using polygenic indices (PGIs) — and adult mental health. We document a childhood SES gradient in the association between genetic risk and anxiety, but not depression. Specifically, individuals who report having been financially well-off during childhood or whose fathers held relatively higher prestige occupations exhibit a substantially weaker association between the anxiety PGI and anxiety symptoms in adulthood. This pattern is not explained by differences in parenting style, parent–child relationship quality, or exposure to childhood stressors and traumas. These findings contribute to the literature on gene–environment interplay by documenting heterogeneity in the association between genetic predisposition and mental health outcomes across socioeconomic contexts. To the extent that financial resources moderate the association between genetic risk and anxiety, early-life economic conditions may be associated with differences in the manifestation of genetic predispositions, with implications for understanding inequalities in mental health.

▶ Dynamics of social inequalities in severe COVID-19 outcomes in metropolitan France from 2020 to 2022

SMAÏLI, S., *et al.*

2025

Communications Medicine 5(1): 516.

https://doi.org/10.1038/s43856-025-01214-w

Evidence on the dynamics of social inequalities throughout the COVID-19 healthcare pathway in France is sparse. This study examined the relationship between area-level social deprivation and hospitalizations, intensive care unit (ICU) admissions, and deaths in metropolitan France during five pandemic waves (wave 2: 1 July-16 December 2020, wave 3: 23 December 2020-16 June 2021, wave 4: 23 June-20 October, wave 5: 27 October-2 March 2022, wave 6: 9 March-31 August 2022).

▶ Associations between adverse childhood experiences and oral health in Norwegian adults, and the impact of social support and adulthood revictimization. The HUNT4 Survey

SØRBØ, M. F., *et al.*

2026

European Journal of Public Health 36(1): 84-90.

https://doi.org/10.1093/eurpub/ckaf229

Adverse childhood experiences (ACEs) increase the risk of various health issues, including oral problems. ACEs also heighten the risk of revictimization, though the impact of adulthood revictimization on oral health is less understood. Conversely, positive influences, such as a trusted adult in childhood, may buffer these effects. This study examines how different dimensions of adversity relate to oral health. This cross-sectional study included 37 559 adults from the HUNT4 Survey, a general population study in Norway. We examined distinct ACE exposures: (i) specific ACEs (i.e. sexual, physical and psychological abuse, bully victimization, parental divorce, and death of a parent), (ii) cumulative ACE, (iii) combined exposure of ACE and adult support, and (iv) adversity trajectories identified by group-based

trajectory modelling of ACE and adulthood sexual, physical and psychological abuse. Associations with oral health were assessed by logistic regression, estimating odds ratios with 95% confidence intervals. Most ACE types were associated with poorer adult oral health outcomes, exhibiting a dose–response gradient, where one-unit ACE increase indicated a higher likelihood of self-reported poor dental health (28%), dental fear (31%), and no dental visit in the last 2 years (10%). Combined exposure of ACE and adult support showed that those with high support had lower odds of reporting poor oral health. The revictimized trajectory exhibited the strongest association with impaired oral health outcomes. Our findings support that ACEs are linked to poor oral health later in life, especially among those revictimized as adults, whilst supportive childhood relations may buffer this effect.

Educational and gender gaps in cognitive health expectancy across Europe: A prevalence-based analysis using SHARE

STONKUTE, D., *et al.*

2026

Social Science & Medicine 391: 118886.

https://doi.org/10.1016/j.socscimed.2025.118886

Variations in the accumulation and decline of cognitive reserve across different cultural and institutional contexts, as well as selective survival processes that influence which population groups remain at risk for cognitive impairment, may contribute to the heterogeneity of educational disparities in cognitive health across European countries and between genders. We explore how educational disparities in Cognitive Health Expectancies (CHE) for men and women vary across different contextual settings in Europe. Applying multivariate life table approach and the Sullivan methods to the Survey of Health, Ageing and Retirement in Europe (SHARE) data, we estimated CHE by gender and education at age 50 and the proportion of CHE relative to remaining life expectancy, across 10 European countries. We found that educational inequalities in cognitive health significantly vary by national context, with some of the most pronounced effects in CEE countries, particularly for women. Despite higher overall educational attainment in CEE countries, the benefits typically associated with education did not translate equally across groups. The key divergence, which is most pronounced for women, occurs among those with low educational attainment, who appear to be highly disadvantaged. Substantially smaller disparities, such as observed in Northern European countries, suggest untapped potential for mitigating educational inequalities in cognitive ageing.

Mortality disparity by socioeconomic position in people with and without diabetes: open cohort studies in four high-income countries

TER BRAAKE, J. G., *et al.*

2026

European Journal of Public Health 36(1): 25-31.

https://doi.org/10.1093/eurpub/ckaf201

There have been mixed findings on whether mortality is socially patterned among people with diabetes. We compared all-cause mortality trends by socioeconomic position (SEP) among people with and without diabetes for 2004–21 in four high-income countries. We conducted open cohort studies in Australia, Denmark, the Netherlands, and Scotland and included national or regional populations aged 35–69 years. We used the European standard population in 2013 to calculate age-standardized mortality rates (ASMRs) by calendar year, SEP quintile, diabetes status, and sex. SEP quintiles were defined using standardized disposable household income in Denmark and the Netherlands, and area-based indices in Australia and Scotland. We calculated the age-standardized slope index of inequality and age-adjusted relative index of inequality using Poisson regression as absolute and relative measures of socioeconomic inequality, respectively across the study populations stratified by calendar year, diabetes status, and sex. About 208 011 deaths occurred during 17 million person years (py) of follow-up among 35- to 69-year olds with diabetes, and 1.1 million deaths during 298 million py of follow-up among people without diabetes. ASMRs generally increased with increasing deprivation and varied between 1.3 (95% CI: 1.2–1.4) deaths per 1000 py to 29.4 (95% CI: 26.0–32.8) deaths per 1000 py. We found absolute and relative mortality inequality that increased during the follow-up period among adults without diabetes. Measures of absolute and relative inequality among adults with diabetes widened in some populations by country and sex. To conclude, disparities in mortality by SEP increased during follow-up in most countries. Strategies are needed to reduce excess mortality associated with low SEP and diabetes and related socioeconomic inequality.

Spatial and social inequities in access to essential healthcare services: a case study of a fast-growing, diverse Canadian city

TIWANA, A., TRAN, M., DRAEGER, C., *et al.*

2026

Health & Place 98: 103640.

https://doi.org/10.1016/j.healthplace.2026.103640

Access to healthcare services remains a persistent challenge, disproportionately affecting vulnerable populations. Limited access results in lower service utilisation and worse health outcomes, hindering progress toward inclusive and sustainable cities. This study developed a novel methodological framework integrating high-resolution (1-km2) socio-demographic data from the 2021 Canadian Census with an advanced multimodal transport routing engine (R5) to assess healthcare access via public transit in Surrey, British Columbia – a fast-growing, diverse city. Using a 30-min travel time threshold, we computed destination-oriented ('passive') and origin-oriented ('active') accessibility to walk-in clinics, urgent care centres, and hospitals. Eco-intersectional multilevel modelling was applied to examine accessibility inequalities across intersectional strata, defined as areas with a high concentration of vulnerable populations based on age, sex, race/ethnicity, education, income, and urbanicity (>vs. ≤ 400 people/km2). Overall, 319,402 (56.2%) residents could reach at least one healthcare facility within 30 min via public transit. Walk-in clinics were the most accessible, followed by urgent care centres and hospitals. Many vulnerable populations were concentrated near major urban centres, which generally had access to more facilities than the city's periphery and outer suburbs. Strata with a high concentration of females had higher odds of accessibility, while seniors and non-urban areas had lower odds. Access inequalities were most pronounced among senior visible minority communities living in non-urban areas. Equity-oriented planning and investments in sustainable transportation and healthcare infrastructure are required to close accessibility gaps. This scalable, open-data framework can inform inclusive urban policy and improve access to essential services for underserved communities.

Intersectional inequalities in interpersonal discrimination in outpatient care according to sex, history of migration, and income in Germany

VON DEM KNESEBECK, O., *et al.*

2025

European Journal of Public Health 36(1): 20-24.

https://doi.org/10.1093/eurpub/ckaf162

Experiences of interpersonal discrimination in outpatient care (e.g. being treated disrespectfully) are a frequent phenomenon in Germany and in other countries. It can be expected that such experiences contribute to the production and perpetuation of health inequalities. We explored intersectional inequalities in interpersonal discrimination in outpatient care according to sex, history of migration, and income. Analyses were based on an online survey in a random sample of the adult population in Germany (n = 3246). A modified version of the Everyday Discrimination Scale was used to assess frequencies of interpersonal discrimination experiences in outpatient care. Sex, history of migration, and net income were considered as indicators of social inequalities. Intersectional multilevel analysis of individual heterogeneity and discriminatory accuracy (MAIHDA) was conducted. Analyses showed significantly higher frequencies of interpersonal discrimination experiences for females and respondents with a low income while associations with migration history were not significant. Social inequalities in discrimination experiences were attributable to additive (and not multiplicative) effects of sex, migration history, and income, with sex contributing most and migration history least to these inequalities. Analyses across the 18 intersectional strata (combining subgroups of sex, income, and migration history) revealed significant differences in frequencies of discrimination experiences between the most (female second-generation migrants with low income) and least affected strata (men with high income and no migration history). As such discrimination experiences can result in reduced health care engagement and adverse health outcomes, these findings point to an important public health issue.

Using lifespan variation to better understand long-term trends in health inequalities in Scotland and Europe

WALSH, D., *et al.*

2026

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Cross-country comparisons of socioeconomic inequalities in mortality/life expectancy (LE) face limitations regarding the comparability of population subgroup data. One potential alternative which can overcome this limitation is lifespan variation (LV). Our aims were to: (i) compare long-term trends in LV across Western European countries, focussing on Scotland as a country with known wide LE inequalities; and (ii) explore the validity of LV through comparisons with ranked measures of socioeconomic inequalities in mortality/LE within Scotland. We calculated e† (one measure of LV) using Human Mortality Database data from 1855 to 2021 for European nations, by sex. We then compared e† with absolute inequalities in mortality and LE by ranked area-level socioeconomic deprivation for all 32 local government areas in Scotland. Male and female LV in Scotland is the highest in Western Europe. For males especially, this resulted from increases in the 1980s–1990s, and was made worse by further increases in the early 2010s. All UK nations have relatively high LV, especially among females. Comparisons of sub-national, area-based, data show a moderate level of correlation between ranked LV and absolute socioeconomic inequalities in mortality (0.57), and male (0.48) and female (0.51) LE. For cross-country comparisons, LV may be a useful proxy for absolute socioeconomic inequalities in mortality/LE where comparable socioeconomic measures are not available; however, it requires cautious interpretation. Given the high level of, and recent increases in, LV in Scotland and the UK, the need for socioeconomic policies to narrow health inequalities has never been more urgent.

Experienced economic segregation and associated mental health inequalities across urbanicity

ZHOU, Y. ET LU, Y.

2026

Social Science & Medicine 389: 118813.

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The global mental health burden is rising, with economic segregation as a key social determinant contributing to mental health and its inequalities. However, most studies rely on residential-based segregation measures failing to capture the actual segregation individuals experience through daily mobility and activities. Using a large-scale mobility dataset across the contiguous United States, we quantify mobility-based economic segregation and examine its associations with mental health outcomes across income groups and urbanicity levels. We find that individuals in the lowest and highest income quartiles exhibit strong self-segregation. A 0.1-unit increase in economic segregation is observed to be associated with a 0.64 % (95 % CI: 0.60 %–0.68 %) rise in poor mental health prevalence among lowest income quartile groups and a 0.29 % (95 % CI: 0.26 %–0.32 %) decline among highest income quartile groups in metropolitan areas. In less urbanized areas, the adverse mental health impacts of mobility-based economic segregation remain significant for low-income groups, while no significant health impact is observed for high-income groups. These findings suggest that mobility-based economic segregation may intensify economic disparities in mental health outcomes. Interventions that enhance upward social mixing for low-income individuals through changes in their mobility may help reduce adverse impacts of economic segregation on mental health and mitigate associated inequalities.

Médicaments

Pharmaceuticals

Economic Evaluations of Medication Safety Interventions in Primary and Long-Term Care: A Systematic Review

AMRITLAL, S. T., *et al.*

2026

PharmacoEconomics 44(3): 299-316.

https://doi.org/10.1007/s40273-025-01567-z

Most medication errors occur in primary and long-term care, and a wide range of medication safety interventions have been implemented, but these are often expensive, with little evidence around cost-effec-

tiveness. We report a systematic review of economic evaluations of these interventions within primary and long-term healthcare settings.

Méthodologie – Statistique

Methodology-Statistics

▶ Bringing together realist and economic approaches in the evaluation of health and social care interventions: a scoping review of theoretical, methodological and practical implications

FLETCHER, A., *et al.*

2026

Social Science & Medicine 393: 119050.

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Background In the evaluation of complex interventions, economic evaluations aim to determine the relative cost-effectiveness of interventions but generate little explanation of how or why contexts and underlying causal mechanisms impact this. Conversely, realist approaches aim to explain 'what works, for whom, in which circumstances and why' but rarely capture the economic costs and consequences of interventions. As a result, many evaluations remain partial. Objective To identify past attempts to integrate realist and economic evaluation approaches and summarise the recent developments in realist and economic evaluation approaches in the evaluation of complex health and social care interventions. Methods We conducted a series of scoping reviews using online academic databases, personal libraries and expert stakeholder workshops, to identify the theoretical, methodological, and practical challenges and developments in bringing together realist and economic evaluation approaches. Findings and recommendations Although increasing, there remain relatively few examples of evaluations that have attempted to integrate realist and economic evaluation approaches, and challenges for their integration mean that further guidance is required. The wider literature indicated challenges in the theoretical (e.g. ontology, causality), methodological (e.g. accounting for context, study design, mixing methods) and practical (e.g. terminology, scale and scope) domains, for which we have developed recommendations. Conclusion To deliver services that are both effective and efficient, evaluations must synthesise relevant explanatory evidence with cost and outcome data to enable policymakers and commissioners to make informed decisions. Findings and recommendations from this review were used to inform the development of guidance for the integration of realist and economic evaluation approaches.

▶ Survey data collection during the COVID-19 pandemic in Germany: Recommendations for an improved data collection infrastructure

GUMMER, T., *et al.*

2026

Health Policy 165: 105551.

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The COVID-19 pandemic created a high demand for rapid data collection while also posing major challenges to collecting timely, high-quality population survey data on public health, and health-related behavior and attitudes. In the Survey Data Collection during the COVID-19 Pandemic (SDCCP) project, we examined how data collection standards evolved during the pandemic and what challenges the national survey infrastructure in Germany was facing. Our findings revealed trade-offs between speed and data quality and a lack of preparedness for rapid data collection. Existing surveys struggled to remain operational and maintain their high standards, whereas newly established surveys were more likely to implement survey designs associated with lower data quality. In this policy comment, we recommend targeted investments in methodological research, operational nationwide emergency planning, and policy changes to support closer collaboration between survey infrastructures.

The 'Values in Modelling' Framework for Patient and Public Involvement in Health Economics Modelling: Development and Application in the LEAP Model Project

HARVARD, S., *et al.*

2026

PharmacoEconomics 44(2): 115-139.

https://doi.org/10.1007/s40273-025-01561-5

Patient and public involvement (PPI) in health economics modelling is increasingly recommended, yet formal guidance for how to structure or evaluate it remains limited. The Values in Modelling (VIM) framework was developed to address this gap by helping teams identify and deliberate on value-laden decisions in modelling. Drawing on philosophical theory, the framework defines five steps to guide collaboration between modellers and transdisciplinary participators and to document their influence on decision making: (1) identify ethical issues and perspectives; (2) characterize modelling decisions; (3) select decision-making strategies; (4) deliberate 'open' decisions; and (5) report and evaluate. We applied the VIM framework in the Lifetime Exposures and Asthma Outcomes Projection (LEAP) model project, which models the cost effectiveness of high-efficiency particulate air (HEPA) filters for asthma prevention and management. In this application, the framework helped prioritize modelling decisions for PPI, supported transparent deliberation about uncertainty, and led to concrete methodological changes—including new sensitivity analyses and revised outcome measures. These results demonstrate how a theory-informed process can enhance PPI in modelling, improving transparency, justification, and adequacy-for-purpose in health economics research.

Exploring heuristics and assessing their impact in discrete choice experiments: a proof-of-principle

MARCETA, S. M., *et al.*

2026

Social Science & Medicine 394: 119044.

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Objectives Using Discrete Choice Experiments (DCEs), healthcare researchers can model population, patient, staff or provider preferences and choices. DCEs are rooted in Random Utility Theory (RUT), assuming that respondents are fully rational and process all provided information when choosing the alternative that maximizes their attribute-based utility. However, these behavioral premises do not always reflect observed behavior in choice experiments. The often complex, uncertain, and emotion-laden choice scenarios in health contexts can prompt heuristic-based simplifications, violating RUT assumptions. Although heuristics are recognized as behavioral violations relative to the normative RUT-based perspective, their impact is rarely modeled and limited guidance exists on how to do so. Methods Using three existing DCE studies, we demonstrate how researchers can identify and assess the impact of common RUT-violating heuristics in applied DCE studies. A structured interview guide and rating instrument were developed to identify heuristics a priori, based on clinician and researcher input. Latent-Class Models with restricted parameters were pre-specified to estimate heuristic impacts vis-à-vis preference heterogeneity. Results Our sensitivity analyses showed that up to 22% of the respondents likely applied particular heuristics. This impacted study results: For example, accounting for dominant decision-making (i.e., a class in which respondents ignored any attributes other than the risk of side effects), increased respondents' average willingness-to-pay for antibiotics with a low contribution to antibiotic resistance by 15,63 Euros per treatment. Conclusions Ignoring heuristics that violate RUT assumptions biases preference estimates, marginal rates of substitution and uptake predictions in DCEs. We recommend assessing the likely presence and impact of heuristics in sensitivity analyses of future DCEs to ensure robustness and accuracy of results.

A scoping review of preference-based instruments for measuring carer outcomes in economic evaluations

MCCAFFREY, N., *et al.*

2026

Social Science & Medicine 390: 118762.

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Carer-specific preference-based instruments have been developed to capture outcomes for economic evaluations but the body of evidence has yet to be collated to guide instrument selection and identify knowledge gaps for future research. This scoping review aimed to identify carer-related, preference-based instruments and summarise and assess their performance, valuation and application. Nine databases (ASSIA, CINAHL, Cochrane, DARE, Econlit, EMBASE, iHTA, PsychINFO, Pubmed) were searched until 28th May 2025 to identify peer-reviewed, English-language articles about

the development, validation, valuation and application of preference-based, carer-related instruments. Study characteristics, instrument descriptions, psychometric properties and valuation information were extracted. The body of evidence and reporting quality were assessed using CREATE and the ISOQOL minimum standards for patient-reported outcome measures. In total, 140 included articles reported on five instruments: the ASCOT-Carer; the CarerQol; the CES; the ICECAP-CPM; and the SIDECAR. All carer-specific, preference-based instruments have rigorously developed scoring algorithms, albeit for differing numbers of countries. All of the instruments, except the ICECAP-CPM, have some evidence of psychometric validity in varied populations, though information on responsiveness is limited. Broadly, the CarerQol, the longest established instrument, is the most widely validated, followed by the ASCOT-Carer and CES. The SIDECAR and ICECAP-CPM require further testing. The CarerQol has the most evidence for use in carers of children, the ASCOT-Carer for adult social care settings, the CarerQoL and CES for the palliative care setting, and the ASCOT-Carer, CarerQoL, and CES for mental illness, rheumatoid arthritis, long-term care, and dementia. The CarerQol, CES and ASCOT-Carer represent the most widely used instruments for measuring carer-related outcomes in economic evaluations. The review findings assist with selecting instruments for studies alongside research objectives, population and settings. Future research should explore the responsiveness of these instruments, validate them in different countries and carer populations, and develop country-specific scoring algorithms.

Politique de santé

Health Policy

Political trust and health compliance during a health crisis: A systematic literature review from the COVID-19 pandemic

GOREN, T., *et al.*

2026

Social Science & Medicine 395: 119093.

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Political trust is considered crucial for enhancing civic compliance with government policies and instructions, particularly during a health crisis. However, evidence from the COVID-19 pandemic, a major global health crisis, suggest a more nuanced relationship. Aiming to explore and clarify the nature of and the conditions for the political trust and civic compliance relationship in the context of a health crisis in the general population, at the overall societal-level, this study systematically reviews relevant literature from the COVID-19 pandemic, across 62 countries. Our findings indicate that the positive relationship between political trust and compliance is not self-evident, as 42% of the reviewed studies (63 of 151) report non-significant, mixed or negative results. Moreover, conceptual and methodological features seem to affect the likelihood of this association, such as the object of trust and compliance behavior, the behavior's execution timeframe and its legal status, and the manner in which political trust and compliance are measured. Potential consequences are discussed.

The politics of integrating health systems and public programs: a review of political headwinds, tailwinds, and policy maker recommendations

KAVANAGH, N. M., MENON, A. ET MCINTYRE, A.

2026

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Amidst low trust in public institutions, policy makers and scholars have proposed using the health system to help rebuild trust in other institutions. One potential mechanism to do so is linking the health system with public programs, e.g. simple referrals, shared financing, or delivering social services via the health system. While other reviews have examined the technical aspects of such linkages, few have examined the political calculus involved. We conducted a narrative review of the academic and grey literature on the relationship

between health and trust in public institutions, as well as political considerations when integrating health systems and social programs, including the attitudes, concerns, and constraints of beneficiaries, stakeholders (e.g. service providers), and political actors. For beneficiaries, attitudes about the health system are associated with attitudes about public institutions, and linking the health system to less popular public programs has been shown to increase engagement in the latter. However, unsuccessful handoffs and administratively burdensome social programs can alienate beneficiaries. Stakeholders are often eager to partner in linkages but can become frustrated by redundant roles and uncoordinated financing. For political actors, embedding social services in the health system may be logistically easier than maintaining standalone programs, but it may also result in weaker long-term public support. Thus, linking health systems and public programs can produce mutual "co-benefits" when done well. At the same time, policy makers must consider the political trade-offs inherent in the linkage. Future research should directly test whether these linkages causally impact broader social outcomes, such as political trust.

The politics of health: exploring the potential and the limits of health in all policies under multilevel governance

KOIVUSALO, M., VALENTINE, N., WILLIAMS, C., *et al.*

2026

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The Health in All Policies (HiAP) approach has been the main focus for intersectoral action for health and heath equity but has proved challenging as result of other political and economic priorities of governments and the multilevel nature of policymaking. This article explores the role of HiAP in changing politics and policy context. The article takes a critical appraisal on how HiAP has been conceptualized and used to compare concepts associated with HiAP. It assesses the limits and potential for the use and application of different concepts drawing from a realist evaluation in understanding why, how, and for whom and in what context they work for HiAP. Illustrative case studies focus on the substance and provide examples from work with Ministries of Finance, Employment and Education. HiAP can be seen as a flexible overarching approach, which provides scope for action through several concepts and practices for intersectoral work. The comparison shows that definitions matter to the practice of HiAP concerning priorities, ideological premises, and level of governance. Ministries of Finance are crucial for action on equity and social determinants of health. HiAP requires understanding of health policy priorities and competences and capacities in public health and health systems governance as well as in analysis of politics, power, and different contexts of policymaking under multilevel governance. While HiAP aims to ensure health priorities in decision-making of all policies, if and how this is realized, is a political choice.

Urban health research: shaping integrated policies for health, equity, sustainability, and climate

SUBIZA-PÉREZ, M., PÉREZ, K., ROUÉ-LE GALL, A., *et al.*

2026

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Urban health is the study of how the physical, social, and cultural features of cities contribute to the unequal distribution of health, disease and overall well-being of urban dwellers. The widespread implications of climate change and other global environmental phenomena are increasingly recognized as major threats to urban health. Shifting from a 'Health in all Policies' to a 'Health for all Policies' approach, policies from different sectors are to be planned and implemented to achieve shared and specific goals. With the aim of considering how urban health interventions and policies interact across sectors, we selected three integrated urban health policies and interventions developed at various governance levels in different parts of Europe. We also offer guidance on how to establish fruitful collaborations with policymakers, stakeholders and citizens in the pursuit of healthier and more sustainable cities. Selected case studies were (i) the local clean air zone implemented in Bradford (UK), (ii) a regional urban renewal policy developed in Barcelona (Spain), and (iii) a European multi-city consortium for healthy and sustainable school meals. We were able to identify impacts beyond health and map their contribution to the UN's Sustainable Development Goals. Well-designed urban health research can address the multiple health, social and ecological challenges of our time by generating the evidence needed to design and evaluate urban policies and translating this evidence into population health and well-being.

Medicalizing the social determinants of health and the inadvertent reproduction of inequities through social-care program implementation in the United States

PFEIFFER, E. J. ET MENDEZ, S.
2026
Social Science & Medicine 392: 118981.
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Social scientists have long noted the influence of social, economic, and political factors—or the social determinants of health (SDOH)—that influence people's health. Healthcare providers and insurers, hospital administrators, clinicians, government, social services, and research agencies have put great efforts into developing policies that create knowledge and awareness, and promote social-risk screening and social-care programs in the United States. These programs screen patients for risks so health professionals can refer them to resources for help with their health-related social needs (HRSN). Federal policies have constructed the socioeconomic conditions of individuals as health problems—and driven SDOH medicalization. While commendable, such programs have not significantly improved patients' health, and the open questions are how and why this is the case. Our qualitative data help answer these questions and inform arguments about the benefits, limitations, and consequences of SDOH medicalization. In our research, we explore study participants' lived experiences of SDOH medicalization in one social-risk-screening-and-care program—from focus-group discussions with clinic staff, patients, and social service leaders collected in 2020–2021. Data provide empirical evidence that medicalization offered benefits but played a role in some unintended negative consequences, including the reproduction of already existing inequities that limited program effectiveness. Efforts to address the HRSN of individuals will be enhanced by policy and clinical work that tackle the intersecting social, economic, and political forces that create and sustain conditions that are harmful to human lives.

Prévention

Prevention

The Role of Price Variation in Economic Analyses for Cancer Screenings: A Rapid Review

TRIANA, A. J. ET ALFORD-HOLLOWAY, M. N.
2026
Applied Health Economics and Health Policy 24(2): 287-292.
https://doi.org/10.1007/s40258-025-01007-1

Health care spending continues to rise, and recent policies have made prices more visible. Purpose :To assess how cost effectiveness analyses obtain price information for common cancer screenings and account for price variation. Methods:A systematic search of PUBMED was conducted, extracting studies from 2021 to 2024 in English and evaluating health care services in the USA. Cost-effectiveness analyses were included for four common cancer screenings: prostate cancer, breast cancer, colon cancer, and lung cancer. A single investigator extracted data and assessed quality, reviewed by a second investigator. Results: A total of 16 articles met inclusion criteria. Nearly all (94%) cited the Medicare Fee Schedule as the data source for pricing information. About half (44%) of analyses included a degree of price variation. Only three articles (19%) performed a cost-effectiveness analysis with a wide degree of price variation that accurately reflected the true degree of price variation observed in empirical data. Limitations: The sample size of included studies was modest, and generalizability is limited beyond these four common cancer screenings. Conclusions : Cost-effectiveness analyses in the USA need to reflect the wide price variation that exists in health care, and publicly available price transparency data should guide future work.

Predictors of Colorectal Cancer Screening Rates in Federally Qualified Health Centers: Explicating Organizational Level Factors

ZAIRE, P. J., *et al.*
2026

Health Services Research 61(2): e70082.
https://doi.org/10.1111/1475-6773.70082

ABSTRACT Objective To examine changes in colorectal cancer (CRC) screening rates over time and determine organizational-level factors influencing these shifts. Study Setting and Design This longitudinal study used mixed effects models to analyze data from Federally Qualified Health Centers (FQHCs) in the United States (US). Key organizational-level factors included Patient-Centered Medical Home (PCMH) recognition and duration, hypertension and diabetes management, and center-level characteristics such as racial composition, location, and center volume/size. Data Sources and Analytic Sample This study used Uniform Data System (UDS) data from 2017 to 2022 for US-based FQHCs receiving full Public Health Service Section 330 grants and reporting CRC screening measures, excluding school-based centers, US territories, and look-alike centers. Principal Findings Among the 1282 FQHCs analyzed, CRC screening rates were increasing before the COVID-19 pandemic but declined during and remain below pre-pandemic levels. FQHCs with consistent PCMH recognition reported significantly higher screening rates (= 8.50, $p < 0.001$). Screening rates were also positively associated with a higher rate of controlled hypertension (= 0.354, $p < 0.0001$) but lower in FQHCs with larger Black patient populations, Southern locations, and smaller center volume/size. Conclusions Consistent PCMH recognition and chronic disease management are essential for improving CRC screening rates in FQHCs. By integrating these population health management strategies, FQHCs can proactively address screening disparities. Prioritizing these organizational-level approaches may strengthen healthcare equity and expand CRC screening for historically marginalized communities.

Psychiatrie

Psychiatry

Born in the USA? A scoping review of deaths of despair research beyond the United States

WILLIAMS, E. H. ET SAVILLE, C. W. N.

2026
Social Science & Medicine 392: 118944.
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Background The concept of 'deaths of despair', initially developed to explain rising midlife mortality among non-Hispanic white Americans, has gained traction globally. However, its applicability and conceptual relevance beyond the United States, where it originated, remain emerging areas of research. This scoping review maps the international use of the concept, examining its geographical reach, methodological approaches, and conceptual adaptations. Methods A comprehensive search of six electronic databases (PubMed, Web of Science, Scopus, CINAHL, PsycINFO, and PsycArticles) yielded 5595 records. Following screening and eligibility checks, 56 articles published between 2018 and 2024 were selected. Data were extracted using a standardised framework and synthesised through a descriptive-analytical approach. Results Research on deaths of despair is concentrated in high-income, English-speaking countries, particularly the United Kingdom and Canada. Most studies utilise mortality-based, quantitative designs, although some incorporate non-fatal indicators such as mental health distress. The literature is characterised by geographical concentration, variable outcome definitions, and gaps in data coverage, which present challenges for cross-national comparison. Conclusions These findings highlight the necessity for greater geographical diversity, conceptual reflexivity, and methodological innovation. A critical examination of the concept's theoretical foundations and cultural fit is essential as it extends beyond the US.

My family member's health and my mental health: A longitudinal matched cohort study

AFOAKWAH, C., *et al.*

2026
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The biobehavioral family model posits that an indi-

vidual's biobehavioral reactivity is influenced by their family's health. This study examined how one's mental health responds to a serious injury or illness to his or her close relative or family member using longitudinal cohort data of Australian adults sourced from the Household, Income and Labour Dynamics in Australia (HILDA) survey. We employed a propensity score matching-difference in differences (PSM-DiD) identification approach to resolve selection bias (both observable and unobservable). We found that those whose close relative or family member suffered any serious injury or illness (exposed group) had significantly lower mental health scores and had higher odds of being time stressed compared to the unexposed group. The mental health effects were more pronounced among females and those with low social capital, while males were more time stressed. Further analyses revealed that while the mental health effects set in after two years post-onset of the injury or illness, time stress starts contemporaneously and persists through to the sixth-year post-injury or illness. The implications of these findings are two-fold: 1) the burden of an illness goes beyond the affected person, hence the need to consider potential spillover effects, including health losses to close family members, when evaluating the impact of illness. 2) Social support packages designed to improve a person's health recovery post-injury or illness should account for the potential unintended health losses to close relatives, as ignoring these spillover impacts could lead to sub-optimal outcomes for families and society.

A systematic review of green gentrification and mental health

BROWN, C. D., *et al.*

2026

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Urban development projects increasingly incorporate greening efforts in underserved communities to improve human health and promote biodiversity. Unfortunately, these efforts can create a paradox whereby target communities do not reap the benefits due to increased property values, and subsequent physical or social-cultural displacement. This process, green gentrification, may negatively affect residents' mental health. Despite increased urban greening efforts, we currently lack a review evaluating the impacts of green gentrification on mental health. Thus, we systematically reviewed the existing green gentrification-mental health research. Through 16 articles, we identified pathways relating green gentrification exposures to mental health outcomes. For instance, as neighborhoods experience green gentrification, rising housing prices introduce new financial pressures and concerns surrounding housing availability and quality, which can introduce stress. Also, as living expenses increase, there is a change in demographics, which can diminish sense of community and feelings of belonging. Furthermore, the green space itself can serve as a space of exclusion as longtime residents experience barriers to use, which have negative implications for their mental health. Finally, when the new green space provides ecological remediation or restoration, longtime residents may experience anxiety due to fear of exposure to historic contaminants. Still, there were some benefits from the green space as it provides a location for relaxation, enhances neighborhood aesthetics, and even improves sense of community. Because of the popularity of urban greening as a public health solution, researchers could incorporate longitudinal designs and assess potential mediators to better assess the role of green gentrification in mental health.

Impact Of Housing Support Services For Medicaid Enrollees With Serious Mental Illness, Substance Use Disorder

BRUEFACH, T., *et al.*

2026

Health Affairs 45(1): 68-75.

https://doi.org/10.1377/hlthaff.2025.00581

In 2019, pursuant to a Section 1115 waiver, Florida launched a Statewide Medicaid Managed Care housing assistance pilot to foster housing stability and reduce preventable health care use in adults with serious mental illness (SMI) or substance use disorder (SUD). We conducted a retrospective cohort study to examine the relationship between four housing support services provided in the pilot (transitional housing support, tenancy support, peer support, and crisis management) and health care use and health outcomes among 1,300 pilot enrollees during the period December 2017–June 2024. Transitional housing support services were associated with a 15 percent increase in emergency department (ED) visits. Tenancy support services were associated with 51 percent lower odds of all-cause mortality, and peer support was associated with a 20 percent reduction in ED use. Crisis management was associated with a 45 percent increase in ED visits, a 41 percent increase in outpatient visits, and a 90 percent increase

in psychiatric hospitalizations. Findings highlight the value of tailored Medicaid housing interventions for people with SMI or SUD. Medicaid policy should prioritize high-value, data-driven housing interventions and protect them from budget cuts. Embedding such services within managed care contracts and aligning them with broader care coordination strategies offer a viable path for sustainability.

L'universitarisation des territoires en psychiatrie – faciliter l'accès aux soins, lutter contre la désertification médicale

HORN, M.

2026
L'Encéphale 52(1): 101-103.
https://doi.org/10.1016/j.encep.2025.04.009

Résumé Les troubles psychiatriques sont en constante augmentation, alors que l'accès aux soins pour les personnes qui en souffrent devient de plus en plus difficile. Dans cet article, nous présentons le Projet de Liaison Universitaire de TerritOire du Nord (PLUTON), une initiative visant à promouvoir l'accès aux soins psychiatriques sur un territoire de la région Hauts-de-France et à lutter contre la désertification médicale. Conçu à l'origine pour répondre à une situation de crise sanitaire, PLUTON a progressivement évolué pour repenser l'organisation des soins psychiatriques d'un territoire. Son objectif était de préserver la structuration des soins de secteur tout en leur insufflant une dimension universitaire dans les domaines cliniques, de recherche et d'enseignement. La réussite de ce projet est le fruit d'une approche innovante et collaborative, fondée sur la mutualisation des ressources existantes. Cette méthodologie désormais éprouvée permet de reproduire aisément et efficacement le projet dans d'autres territoires. Mental disorders are on the increase, while access to care is becoming increasingly difficult for those affected. This article presents the "Projet de Liaison Universitaire de TerritOire du Nord" (PLUTON), an initiative to improve access to psychiatric care in an area of the Hauts-de-France region and to combat medical desertification. Initially conceived as a response to a health crisis, PLUTON has gradually evolved to rethink the organisation of psychiatric care in a given area. The aim was to preserve the structure of sector-based care while adding a university dimension to clinical, research and teaching activities. The success of this project is the result of an innovative, collaborative approach based on the pooling of existing resources. This tried and tested methodology means that the project can be easily and effectively replicated in other areas.

Addressing Psychiatric Bed Capacity: Evidence From Medicaid's Institutions for Mental Disease Waivers for Serious Mental Illness

JOHN MCCONNELL, K., *et al.*

2026
Health Services Research 61(1): e70051.
https://doi.org/10.1111/1475-6773.70051

ABSTRACT Objective To assess whether the adoption of Section 1115 Serious Mental Illness and Serious Emotional Disturbance (SMI/SED) Medicaid waivers was associated with increased bed capacity among freestanding psychiatric hospitals. Study Setting and Design We used a difference-in-differences design to study changes in bed capacity in freestanding psychiatric hospitals across all 50 states and the District of Columbia, comparing states that adopted waivers to those that did not. Data Sources and Analytic Sample We used data from the National Mental Health Services Survey, Centers for Medicare and Medicaid Services Provider of Service files, and other state-level datasets from 2014 to 2023. Principal Findings Freestanding hospitals were responsible for most of the growth of psychiatric inpatient bed capacity over the last 10 years. We found no correlation between the option to pursue an SMI/SED waiver and bed capacity or other measures of mental health needs, including state-based estimates of SMI prevalence or suicide rates. In our difference-in-differences analyses, we found no association between the adoption of SMI/SED waivers and bed capacity in freestanding psychiatric hospitals. For example, our estimate of the association of SMI/SED waivers with changes in beds in psychiatric hospitals that accepted Medicaid was −24 beds per 100,000 Medicaid-enrolled adults (95% CI: −115, 67). Other specifications and outcome variables yielded similar results. Conclusion While SMI/SED waivers offer the potential to address psychiatric bed shortages, these waivers alone may not suffice to increase inpatient capacity. Given the low uptake and absence of significant change in bed capacity, SMI/SED waivers may need to be redesigned to meet the growing mental health needs of the Medicaid population.

An ethnographic study of diagnosis of physical illness in people with mental health conditions in the emergency department

LIBERATI, E., *et al.*

2026

Social Science & Medicine 391: 118927.

https://doi.org/10.1016/j.socscimed.2026.118927

People living with mental health conditions face reduced life expectancy, largely associated with under-diagnosed and under-treated physical illnesses. Inequalities in the way physical symptoms are diagnosed may be implicated in these outcomes, but, to date, studies have primarily understood these inequalities in terms of 'diagnostic overshadowing': the misattribution of physical symptoms to mental health conditions. In this paper, we use the candidacy framework to offer an extended analysis of the influences on diagnosis of physical health symptoms in people with mental health conditions presenting to the emergency department (ED)—a crucial node in the diagnostic pathway. We conducted a multi-site ethnography in three English EDs, including 284 h of non-participant observation and 43 interviews with clinicians, patients with mental health conditions, and accompanying persons. We found that, although the ED was seen as an open door, patients often struggled to have their physical symptoms recognised as legitimate concerns. Some delayed seeking care, feeling less deserving or anticipating dismissal; others tried to enhance their candidacy by downplaying their mental health history. The ED's operating conditions—throughput targets, overcrowded bays, and stretched staffing—favoured presentations that were clear-cut, straightforward, and urgent. This left little room for exploring more complex cases, such as those involving overlapping mental and physical health symptoms. Patients, clinicians and others recognised the risk that implicit bias might affect how physical symptoms in people with mental health conditions were interpreted, and they often sought to mitigate the impacts of such biases. This, however, could create its own risks, as different parties framed and reframed patients' presentations without full knowledge of the adjustments made by others—potentially impacting risks of both under-diagnosis and over-investigation in ways that were difficult to gauge. By applying the candidacy framework and examining the entire ED diagnostic pathway, our study illuminates a range of influences on diagnosis that extend beyond diagnostic overshadowing.

Corrigendum to "Parenthood and mental health: Findings from an English longitudinal cohort aged 32" [Soc. Sci. Med. Volume 383, October 2025, 118471]

MANSFIELD, R. ET HENDERSON, M.

2026

Social Science & Medicine 383: 118471.

https://doi.org/10.1016/j.socscimed.2026.119011

Enhanced Service Capacity for Severe Mental Illness: A Comparative Analysis of Certified Community Behavioral Health Centers, Community Mental Health Centers, and Federally Qualified Health Centers

MATTHEWS, E. B. ET STANHOPE, V.

2026

Health Services Research 61(1): e70010.

https://doi.org/10.1111/1475-6773.70010

ABSTRACT Objectives The objective of this study is to update estimates of comprehensive service availability among CCBHCs and compare them to other settings serving individuals with severe mental illness, including community mental health centers (CMHCs) and federally qualified health centers (FQHCs). Study Design and Setting This study is a cross-sectional secondary data analysis. Data Sources and Analytic Sample Using 2022 National Substance Use and Mental Health Services Survey (N-SUMHSS) data, logistic regression examined associations between service setting (CCBHC, CMHC, FQHC) and the availability of psychiatric, health management, and navigation, and social care services. Principle Findings Compared to CCBHCs, FQHC designation was associated with a decreased likelihood of offering psychiatric rehabilitation services, including ACT (marginal effect = –0.26, 95% CI: –0.33 to –0.19) and peer coaching (marginal effect = –0.36, 95% CI: –0.43 to –0.29), and psychiatric crisis intervention (marginal effect = –0.14, 95% CI: –0.22 to –0.07). Rates of health management services were comparable to those at CCBHCs. CMHCs were also less likely to offer health management services (marginal effect = –0.26, 95% CI: –0.32 to –0.21) and a range of psychiatric rehabilitation services relative to CCBHCs. Conclusions CCBHC certified clinics were more likely to offer psychiatric and social services than FQHC or CMHC clinics serving individuals with severe mental illness.

Strengthening interprofessional collaboration by working with cross-sectoral boundaries: introducing mental health teams in Denmark

MEJSNER, S. B., BURAU, V. ET FEHSENFELD, M.

2026

European Journal of Public Health 36(Supplement_1): i3-i7.
https://doi.org/10.1093/eurpub/ckaf236

Interprofessional collaboration across sectors is a major challenge for the health and care workforce. Collaboration often remains weak, as fragmented services cannot match complex needs. Working with the underlying professional, organizational, and administrative boundaries may help to address the challenge, but we know little about how managers and professionals do this. This study examines how boundary work can strengthen interprofessional collaboration, based on the introduction of mental health teams in three Danish municipalities. A qualitative case study was conducted involving three intersectoral teams consisting of health and social care professionals in Central Denmark Region. Data collection included observations of interactions, 27 semi-structured interviews with users, professionals, and middle managers, and three focus group interviews. Key themes and dynamics in boundary work were identified using thematic network analysis. Findings indicate that boundary work by management established shared frameworks for interprofessional collaboration, such as weekly board meetings and risk categorization systems. In two municipalities, these frameworks fostered collaborative boundary work among professionals, agreeing on how to share information and adjust care plans collectively. However, in the third municipality, professionals competed to defend existing boundaries, hindering the introduction of new collaborative practices. Working with boundaries can help to address the challenge of interprofessional collaboration across sectors by combining top-down and bottom-up strategies by managers and professionals. However, implementation needs fine-tuning to existing professional hierarchies and local organizational contexts. Managers also need to acknowledge the limits of steering boundary work, which thrives on autonomy in daily interactions among professionals.

Réinventer l'électrochoc. Électroconvulsivothérapie, identités professionnelles et résistance thérapeutique dans la psychiatrie de la seconde moitié du XXe siècle

MICHEL-DUMÉNIL, A.

2025

Sciences sociales et santé 43(3): 35-42.
https://doi.org/10.1684/sss.2025.0302

A Critical Examination of the Certified Community Behavioral Health Clinic Model: Provider Perceptions and Themes

OLGAC, T., *et al.*

2026

Health Services Research 61(1): e70041.
https://doi.org/10.1111/1475-6773.70041

ABSTRACT Objective To explore the experiences of providers from two community behavioral health agencies involved in the implementation of Certified Community Behavioral Health Clinics (CCBHCs). Study Setting and Design This qualitative study was conducted as part of a larger evaluation of CCBHC implementation outcomes in two community-based behavioral health agencies. Ninety-one participants, including case managers, counselors, care coordinators, and leadership teams from both agencies, participated in focus group discussions to share their experiences regarding the implementation of the CCBHC model within their organizations. Data Sources and Analytic Sample Three rounds of focus group discussions were held between 2021 and 2023. A total of 24 focus groups were audio-recorded and transcribed by one of the researchers. Qualitative data was analyzed by two researchers using the systematic text condensation method. Principal Findings Six themes emerged from the focus groups reflecting both positive impacts and implementation challenges. Providers reported the implementation of CCBHCs improved service accessibility and effective care coordination; however, staff noted difficulties connecting clients with essential community resources, including housing and transportation. Both agencies underwent significant organizational transformation, although communication strategies varied by agency size. Finally, providers observed improved communication, client benefits (e.g., reduced hospitalizations), and positive organizational change. Despite these successes, agencies expressed significant concerns about long-term program viability due to reliance on temporary grant funding. Conclusion

The CCBHC model of integrated care has expanded significantly in recent years. Most participants reported a positive cultural shift within their agencies following CCBHC implementation. However, limited community resources continue to restrict agencies' ability to address clients' basic needs. Since the CCBHC model was implemented through temporary grant funding, sustainability remains a concern. Both issues underscore the need for policies that increase the availability of community resources and ensure the long-term viability of CCBHCs.

▶ The Causal Effect of Scaling up Access to Psychotherapy

SERENA, B. L.

2025

The Review of Economics and Statistics: 1-52.

https://doi.org/10.1162/REST.a.1679

This paper estimates the causal effect of scaling up access to psychotherapy. I study a 2008 reform of the Danish public health insurance, which introduced 60% coverage for psychotherapy by private practice psychologists for patients aged 18–37 diagnosed with depression or anxiety. Using administrative data from 1995–2019 and quasi-experimental methods, I show that psychotherapy coverage reduces psychiatric hospital contacts, physical health care use, and suicide attempts, but has no effect on labor market outcomes, including employment or disability pension. Still, savings from reduced use of other health care services exceed policy costs, making it both cost-reducing and welfare-improving.

▶ Une innovation à effet retard ? Les neuroleptiques à action prolongée face aux transformations institutionnelles de la psychiatrie (années 1960-2020)

TARTOUR, T.

2025

Sciences sociales et santé Vol. 43(3): 5-34.

https://doi.org/10.1684/sss.2025.0303

Cet article explore l'usage des neuroleptiques à action prolongée (NAP) dans la psychiatrie française de 1966 à aujourd'hui, en articulant trois ambitions complémentaires. D'un point de vue historique, il retrace les dynamiques d'appropriation des NAP, montrant comment leur diffusion accompagne, sans les déterminer, les transformations institutionnelles de la psychiatrie, notamment à travers la sectorisation. Sur le plan socio-anthropologique, l'analyse des pratiques, basée sur des données ethnographiques, des entretiens et des archives médicales, révèle des usages variés des NAP, entre négociation thérapeutique, gestion des patients « observants » et redéfinition des lieux du soin en dehors de l'hôpital. Enfin, l'ambition théorique de l'article est d'interroger la relation complexe entre innovation pharmacologique et transformations institutionnelles. Loin d'un déterminisme technologique, les NAP apparaissent comme des « traceurs » des mutations psychiatriques, dont les significations évoluent selon les contextes.

▶ Momentary associations between time-varying social contacts and depressive symptomatology in older adults: A GPS-based mobility survey study

ZOU, D., *et al.*

2026

Social Science & Medicine 389: 118834.

https://doi.org/10.1016/j.socscimed.2025.118834

Studies often investigate the long-term impact of social contacts on mental health in older adults, neglecting momentary effects. This research, grounded in the consideration of daily activity, explores how time-varying social contacts associate with momentary depressive symptoms among 216 older adults in the Île-de-France region. Employing a geographically-explicit ecological momentary assessment approach (GEMA), we collected participants' depressive symptoms, mobility locations, and social contacts data via smartphone surveys, GPS receivers, and mobility survey over 7 days. Bayesian mixed models with random effects at individual and daily levels, considering time autocorrelation, were employed. Participants engaging with social contacts exhibited lower depression not only immediately but also in the following hours. Interestingly, a longer duration of time spent with social contacts did not lead to a sharper decrease in depression levels. Notably, larger decreases were observed when the number of social contacts increased from one to two, especially with friends or family members.

Sociologie de la santé

Sociology of Health

▶ La prise en compte des femmes dans les essais cliniques : il serait temps de transformer l'essai !

CHARREIRE PETIT, S. ET CORON, C.

2025

Journal de gestion et d'économie de la santé 2(2): 65-82.

https://doi.org/10.54695/jdds.043.2.0065

Notre article vise à mieux comprendre et qualifier l'impact de la sous-représentation des femmes dans les essais cliniques sur les innovations en santé. La prise en compte des femmes dans les essais cliniques a fait l'objet d'un certain nombre de recherches, en médecine, mais aussi en sciences de gestion. Cependant, aucune étude n'a mené d'analyse longitudinale à l'échelle internationale sur la présence des femmes dans les essais cliniques. Fondée sur une base de données recensant de façon exhaustive les essais cliniques publiés sur le site Clinicaltrials, notre recherche montre une inclusion grandissante des femmes dans les essais cliniques (avec une exception pour la phase 1). Cependant, très peu d'essais cliniques distinguent les résultats par genre, et encore moins s'intéressent explicitement aux effets différenciés des traitements en fonction du genre. Ce résultat en trompe-l'œil représente donc une progression inachevée car les différences biologiques et sociales potentielles entre femmes et hommes restent invisibilisées. Nous montrons en quoi l'intégration en pratique du genre, dès l'idéation, dans le processus d'innovation en santé, permettrait de contribuer à l'amélioration de la santé des femmes.

▶ Pourquoi les directives en matière de santé ne sont-elles pas respectées ? Le rôle de la distance envers la maladie et de la réactance envers ces directives

COTTET, P., *et al.*

2025

Journal de gestion et d'économie de la santé 2(2): 3-18.

https://doi.org/10.54695/jdds.043.2.0003

Les incidences du non-respect de directives sanitaires (par exemple, lors d'une pandémie, la distanciation sociale et les gestes d'hygiène) peuvent être désastreuses pour la santé publique. Comment pouvons-nous expliquer de tels comportements ? Cet article cherche à comprendre le non-respect des comportements préconisés d'hygiène, de distanciation sociale et de respect du confinement par la distance envers la maladie. La réactance envers les directives sanitaires est considérée comme un modérateur de cette relation. Lors du premier confinement, une enquête quantitative a été conduite auprès de 5 753 Français âgés de 18 à 86 ans, répartis sur l'ensemble du territoire national. Des tests de médiation et de modération ont été menés. Les résultats montrent que la distance envers la maladie a un effet sur les comportements d'hygiène, de distanciation sociale et de respect du confinement, par l'intermédiaire de l'attitude envers les directives sanitaires. La réactance envers ces directives est un modérateur de la relation entre la distance envers la maladie et l'attitude envers les directives. Afin de réduire les comportements "déviants" vis-à-vis des directives sanitaires, il convient donc de réduire la distance envers la maladie en s'appuyant sur des recommandations qui sont perçues comme très concrètes et très proches. Les gains financiers et sanitaires qui en résulteraient peuvent être considérables. L'originalité de cet article est de mettre en évidence l'importance d'intégrer la distance psychologique comme cadre explicatif des comportements en matière de santé et de montrer la nécessité de prendre en compte un médiateur et un modérateur pour étudier son processus d'influence.

▶ Faut-il avoir peur des comités d'éthique? Contrôles formels et informels dans l'accès aux institutions de soin

DERBEZ, B.

2025

SociologieS.(en ligne)

https://doi.org/10.4000/15ek9

La régulation de la recherche en sciences sociales par des comités d'éthique fait débat depuis plusieurs années en France, notamment pour ce qui est de l'accès au terrain. Face à l'éthique « procédurale » qu'ils promeuvent, inspirée de la biomédecine, certain·es chercheur·es mettent l'accent sur une éthique « en pratique », fondée sur la réflexivité en situation. En

revenant sur deux expériences de recherche dans le domaine de la santé, cet article montre, dans un premier temps, que les refus d'accès aux institutions de soin peuvent être liés à des contrôles éthiques informels sur le terrain et, dans un second temps, que l'évaluation formelle d'un projet par un comité d'éthique peut aussi constituer une ressource pour la réflexivité éthique du chercheur ou de la chercheuse. Ce faisant, il plaide pour une meilleure articulation de ces deux approches de l'éthique dans le processus d'accès aux terrains en santé.

Des formations continues partagées entre médecins hospitaliers et ambulatoires dans un même territoire : un atout pour les relations interprofessionnelles ?

HERNANDEZ, J. ET BALMET, C.

2025

Médecine 21(9): 421-426.

https://doi.org/10.1684/med.2025.1144

Contexte : La relation entre médecine hospitalière et ambulatoire constitue un levier essentiel pour améliorer la coordination des soins. Pourtant, elle demeure fragilisée par des difficultés persistantes de communication et de reconnaissance mutuelle. Dans ce contexte, des initiatives locales de formation conjointe apparaissent comme un moyen de renforcer les liens interprofessionnels et de fluidifier les parcours patients. Méthode : Une étude qualitative a été conduite au Centre Hospitalier du Forez (Loire), à partir de deux soirées de formation communes organisées en 2023 et 2024. Les données ont été recueillies au moyen de focus groups et d'entretiens individuels. Résultats : Au-delà de leur rôle pédagogique, ces formations ont agi comme un catalyseur relationnel. Elles ont réduit les appréhensions, fluidifié les échanges et légitimé les sollicitations réciproques entre médecins de ville et hospitaliers. La convivialité, la proximité géographique et l'ancrage local sont apparus comme des facteurs déterminants. Plusieurs participants ont rapporté des évolutions dans leurs pratiques, notamment une meilleure coordination des prescriptions et un adressage plus fluide. Conclusion : Ces formations constituent un outil concret de décloisonnement entre médecine hospitalière et ambulatoire. Leur pérennité suppose une co-construction plus équilibrée, intégrant davantage les acteurs de ville et soutenue par une reconnaissance officielle.

Étude des facteurs clefs de l'émergence de la confiance patient-médecin au sein d'une communauté en ligne de santé covid-19

ISSEKI, B. ET BUFFAZ, P.

2025

Journal de gestion et d'économie de la santé 2(2): 19-64.

https://doi.org/10.54695/jdds.043.2.0019

Objectif de la recherche : Étudier les facteurs clefs contribuant à l'émergence de la confiance des patients envers les médecins dans une communauté en ligne de santé covid-19. Méthodologie : Étude exploratoire de type ethnographique. Analyse des interactions et de l'organisation au sein de la communauté en ligne. Résultats : Les facteurs identifiés incluent une organisation méthodique des professionnels de santé, la présence de modérateurs, le partage d'informations médicales fiables, la vérification des témoignages et la communication interactive des médecins. Limites et implications de la recherche : Les résultats sont spécifiques à une communauté en ligne de santé covid-19 et peuvent ne pas être généralisables. Implications pratiques : Les résultats offrent des perspectives pour concevoir et gérer des environnements virtuels de santé en mettant l'accent sur la confiance entre les membres. Originalité : L'étude met en lumière le rôle des facteurs organisationnels dans l'établissement de la confiance interpersonnelle au sein des communautés virtuelles de santé.

The health and care workforce crisis: co-benefits of gender-transformative approaches and capacities for implementation

KUHLMANN, E., CZABANOWSKA, K., LOTTA, G., *et al.*

2026

European Journal of Public Health 36(Supplement_2): ii45-ii50.

https://doi.org/10.1093/eurpub/ckaf222

The health and care workforce crisis and gender inequalities are interconnected, threatening healthcare and equity. We turn this 'unhealthy' connection upside down, aiming to explore how health policy can create co-benefits for gender equality and how governance can support policy implementation. A conceptual approach on SDG3 'Health' and SDG5 'Gender Equality' co-benefits served our analysis. We applied a qualitative explorative approach to identify co-benefits;

following a rapid scoping review of the literature, we focus on document analysis and an illustrative case study of artificial intelligence in the health and care workforce. The literature reveals an overall lack of attention to co-benefits in research. Policy documents pay some attention to co-benefits, but primarily consider the benefits for the healthcare sector rather than for gender equality. The case of artificial intelligence illustrates that technological innovations provide opportunities for change, but to create co-benefits, they need gender-responsive and equity-based policy approaches to enhance economically effective and socially fair transformations. We discuss how transformational leadership and gender-transformative governance approaches can support implementation of co-benefits policies. Strengthening the policy and implementation of co-benefits provides novel opportunities for improving gender equality and responding to the health and care workforce crisis.

The privilege to heal? Mapping patients' unequal mobilisation of health capital in a Nordic welfare context

LARSEN, K., *et al.*

2026

Social Science & Medicine 392: 118962.

https://doi.org/10.1016/j.socscimed.2026.118962

In the Nordic egalitarian countries, relative equality is expected in relation to individual health investments and outcomes. This study explores a heterogeneous sample of patients' bodily investment strategies when illness occurs. A questionnaire was conducted with 503 patients from the Capital Region of Denmark. Using Multiple Correspondence Analysis (MCA), the study identifies unequal and distinct patterns of bodily health capital investment. Two dimensions emerged: disruption vs. continuity and liberal vs. conservative. These dimensions revealed opposing patient groups. Active engagement in bodily investment strategies was associated with younger, female, highly educated patients with chronic or disruptive conditions such as heart transplants or psychiatric illnesses. Conversely, lower engagement was observed among older, less educated patients with lower incomes, particularly those treated in departments of comorbidity, geriatrics, or orthopaedics. The analysis further demonstrates that a high volume of health capital is closely tied to social class through the conversion of capitals: we see emerging distinctions of economic and cultural resources which provide patients the dispositions needed, to recognise and mobilise body investment. Thus, the study shows that classed, gendered, and age-based inequalities in healing persist even within a universal welfare system, revealing the enduring social structuring of health capital.

De la « maladie destructrice » à la « maladie métier »

MBARGA, J. ET RIBEIRO, C.

2025

Revue française des affaires sociales 2025(3): 285-302

Expériences de personnes souffrant de douleurs musculo-squelettiques chroniques et de limitations fonctionnelles persistantes à la suite d'un accident.» Revue française des affaires sociales 2025(3): 286-302. Cet article explore la façon dont sont vécues les conséquences d'un accident lorsqu'elles s'étendent sur des temporalités longues. Des observations en ateliers professionnels et des entretiens semi-directifs ont été mobilisés en vue d'étudier l'expérience de personnes participant à un programme de réadaptation du fait des douleurs musculo-squelettiques chroniques et des limitations fonctionnelles mineures à modérées consécutives à un accident. L'analyse des discours et des pratiques révèle que l'accident, lorsqu'il impacte la vie des individus dans la durée, induit, comme dans le cas des maladies chroniques, une rupture biographique qui contraint les personnes qui en pâtissent à s'engager dans une lutte active pouvant potentiellement permettre de reconquérir une certaine « normalité ». Dans une acception non marchande, cette lutte s'apparente à un métier tant elle nécessite une certaine forme d'apprentissage ainsi qu'une acquisition de savoirs voire de compétences.

Soins de santé primaire

Primary Health Care

▶ The Impact of Team-Based Ordering Workflows on Ambulatory Physician EHR Time, Order Volume, and Visit Volume

APATHY, N. C., *et al.*

2026

Health Services Research 61(1): e70038.

https://doi.org/10.1111/1475-6773.70038

ABSTRACT objective To analyze national rates of team-based ordering and evaluate changes in key outcomes following adoption. Study Setting and Design We conducted an observational pre-post intervention-comparison study of 249,463 ambulatory physicians across 401 organizations using the Epic EHR. Our intervention was the adoption of team-based ordering, measured as the proportion of orders involving team support. Outcomes include active ordering time, overall EHR time, order volume, and visit volume among adopter physicians. Data Sources and Analytic Sample We analyzed the distribution and trends in team-based ordering rates from Epic Signal (September 2019–March 2022). We used multi-variable regression in a difference-in-differences framework to evaluate changes in our outcomes among 115 adopters of team-based ordering and 3115 non-adopters. We defined adopters as physicians who demonstrated a one-time shift from 0% of orders to a consistent non-zero share of orders, and non-adopters as those who demonstrated constant 0% teamwork for at least 18 months. Principal Findings Across our study period, 26.2% of orders involved team support, with surgical specialists averaging greater team-based ordering (43.1%) than primary care (22.2%) and medical specialists (23.0%). There was no association between team-based ordering adoption and time spent ordering (−0.13 min/visit, 95% CI: [−0.48 to 0.22]) or total EHR time (−1.42 min/visit, [−3.79 to 0.95]). Adoption was associated with a 26.8% relative increase in order volume (0.47 orders/visit, [0.14–0.80]) and a 22.3% relative increase in visit volume (6.50 visits/week [2.81–10.19]). Conclusions Team-based ordering rates are relatively low, and new adoption of team-based ordering was not associated with physicians' time spent ordering or in the EHR overall. Teamwork may facilitate substantial increases in both order and visit volume, but a greater level of team-based ordering may be required to realize EHR time savings.

▶ An Assessment of the Association Between Wages and Fringe Benefits on Nurse Aide Turnover in Nursing Homes

BRUNT, C. S., *et al.*

2026

Health Services Research 61(1): e70019.

https://doi.org/10.1111/1475-6773.70019

Abstract Objective to assess cost-effective strategies to reduce nurse aide turnover, this study examines the relationship between turnover and compensation, including wage rates, spending on fringe benefits, and specific fringe benefit offerings. Study Setting and Design The study uses national data from 2022 and 2023, a period following major COVID-19 labor market disruptions. The analysis uses regression models to assess the impact of wages and fringe benefits on turnover, with additional subgroup analyses by ownership type (for-profit, not-for-profit, and government). Data Sources and Analytic Sample Data were sourced from Medicare Cost Reports, the Payroll-Based Journal Public Use Employee Detail File, and Care Compare archives. After excluding nursing homes with missing observations and applying exclusions for outliers, the final analytic sample included 19,238 nursing home-year observations from 12,116 unique nursing homes. Principal Findings The results indicate that higher wages and fringe benefit spending are both associated with slightly lower nurse aide turnover. A 10% increase in wages was linked to a 0.28 (95% CI: 0.04, 0.53) to 0.39 (95% CI: 0.09, 0.70) percentage point reduction in turnover, an effect primarily driven by for-profit nursing homes. Fringe benefit spending was significantly associated with lower turnover among for-profits and not-for-profits, with a 1-percentage-point increase in fringe rates reducing turnover by 0.08 (95% CI: 0.01, 0.15) to 0.28 (95% CI: 0.23, 0.34) percentage points. Specific fringe benefits, such as daycare assistance and accident/disability insurance, were associated with lower turnover. A simulation analysis suggests that investments in fringe benefits are more effective at reducing turnover than equivalent investments in wages. Conclusions Nursing homes seeking to reduce nurse aide turnover should consider enhancing fringe benefits in addition to increasing wages. Given the higher cost-effectiveness of fringe benefits in reducing turnover, policymakers and nursing home administrators

should refine these strategies to improve workforce stability and care quality.

Factors That Motivate Provider Switching: The Patients' Perspective

DILLIBE, O., *et al.*

2026

Health Services Research 61(1): e70028.

https://doi.org/10.1111/1475-6773.70028

ABSTRACT Objective To generate evidence regarding the specific critical incidents that prompt patients to switch care providers. Study Setting and Design Building on existing work on customer switching behavior, we applied the critical incident technique (CIT) to the health services research context and analyzed primary data obtained from 555 US-based patients who reported switching providers between 2018 and 2022 to develop a typology of the critical incidents that prompt patients to switch healthcare providers. Data Sources and Analytic Sample Data were obtained from an online survey of adult US-based patients who reported switching primary care providers (PCPs) for non-insurance-related reasons. The survey was conducted from August to September 2022 using a quota sampling approach. Principal Findings We found eight critical incident categories associated with patient switching: service encounter failures, pricing, competitor attraction, inconvenience, core service failures, involuntary switching, breakdown in shared decision-making, and service environment perception. Conclusion We offer explanations and suggest potentially useful evidence-based strategies for further investigation.

Policy responses to doctor and nurse migration in the European Region: insights from nine country case-studies

DUSSAULT, G., ZAPATA, T., BUCHAN, J., *et al.*

2026

Eur J Public Health 36(Supplement_1): i20-i27.

http://www.ncbi.nlm.nih.gov/pubmed/41335409

The WHO Regional Office for Europe conducted 9 country studies of migration of doctors and nurses. This paper identifies similarities and variations in migratory flows, factors that influence them, and related policy responses. The 9 countries include 4 that integrate the European Economic Area (EEA), Ireland, Malta, Norway, and Romania, and 5 non-EEA, Albania, Armenia, Georgia, Moldova, Tajikistan. Case writers used a common study template that covered international outflows and inflows, mobility push, and pull factors, and related policy interventions. Data sources include the WHO/Europe-OECD-Eurostat joint questionnaire and country databases. Emigration is motivated by low wages, dissatisfaction with working conditions, inadequate practice environment, excessive workloads and lack of opportunities for professional development. Flows for doctors and nurses vary in volume over time, and in countries of origin and destination. Pull factors include the free circulation of persons within the EEA for citizens of member states, easy access to work permits, common or easily learned language, and the presence of a diaspora in a destination country. Policies to improve retention include increasing the number of training places, making remuneration and working conditions more attractive and compulsory service. All countries have some health workforce development plan, but implementation is a challenge everywhere. Policies should be tailored to country labour market conditions, migration trends, and institutional capacity. Better understanding of migration flows will improve the effectiveness of policy responses.

Care of Patients With Chronic Conditions and Clinician Participation in Accountable Care Organizations

EVERHART, A. O., *et al.*

2026

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ABSTRACT Objective To compare chronic condition specialists to primary care providers (PCPs) on rates of serving as the usual provider of care (UPC, defined as providing the most visits) versus being accountable under "PCP-first" assignment used in accountable care organization (ACO) programs, and to compare risk-based ACO participation. Study Setting and Design We conducted a retrospective cohort study of PCP versus chronic condition specialty clinicians on their rates of serving as UPC for patients with complex chronic conditions, patient assignment under a "PCP-first" assignment mechanism, and participation in risk-based ACOs. We then estimated linear probability models predicting clinician participation in risk-based ACOs as a function of their rates of serving as the UPC. Data Sources and Analytic Sample We used 100% traditional fee-for-service Medicare (TM) clinician data and beneficiary claims from 2017 to 2022.

Principal Findings The study included 2,065,755 and 254,918 clinician-years for PCPs and chronic condition specialists (cardiology, endocrinology, nephrology, pulmonology), respectively. Specialists more often served as the UPC than they were accountable under PCP-first assignment algorithms (7.9% UPC vs. 3.3% PCP-first assignment); the opposite was true of PCPs (19.2% vs. 29.8%). Specialists in the top quintile for serving as UPC were 19.0% less likely (4.4 percentage point [pp] absolute difference, 95% CI, 3.7–5.1 pp) to participate in risk-based ACOs than specialists in the bottom quintile. PCPs in the top UPC quintile were 18.7% more likely (3.8 pp. absolute difference, 95% CI, 3.6–4.1 pp) to participate in risk-based ACOs than PCPs in the bottom quintile. Conclusions Existing assignment mechanisms in Medicare ACOs may undervalue specialists' care for patients with chronic conditions. More efforts are needed to engage specialists in accountable care.

Nurse practitioner training and local medical provider supply

GRUBER, A. F., *et al.*

2026

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The Nurse Practitioner (NP) workforce expanded rapidly from 2010-2023, especially in rural counties, where patients today are nearly as likely to receive care from an NP as from a physician. At the same time, rural health outcomes and access to health care continue to worsen relative to urban areas. Empirical research on how NPs interact with or substitute for physicians remains limited. This paper exploits county-level openings of graduate nursing programs to test how they impact the local supply of NPs and primary care physicians. Using data from the Integrated Postsecondary Education Data System and Area Health Resource Files, we estimate staggered difference-in-differences frameworks. We show that new graduate programs lead to large increases in the local NP supply and find positive spillover effects for nearby rural counties and counties with low provider to population ratios. We find that over the decade after a program first graduates students, up to 30% of students become licensed NPs in the same county, and for rural programs, the majority of graduates add to the regional supply of NPs. We find no adverse impact of local NP increases on the number of primary care physicians, suggesting that broader access to NP education boosts the local supply of providers overall. This paper illustrates the importance of rural medical education in increasing local access to primary care providers and in addressing existing inequities in access to care.

Experiences of Maryland Primary Care Practices in Addressing Social Needs Through a Novel Value-Based Payment

GRUBER, E., *et al.*

2026

Health Services Research 61(1): e70058.

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ABSTRACT Objective To understand perceived successes and challenges of the HEART payment, and opportunities for similar value-based payment mechanisms aiming to address health-related social needs. Study Setting and Design This study analyzes perceptions of primary care practices participating in the Maryland Primary Care Program (MDPCP) on the HEART payment, a value-based payment designed to support patients' social and medical needs. After a year of payment implementation, we gathered feedback through participant surveys and focus groups. Data Sources and Analytic Sample From February to March 2023, we administered a survey with 112 responses and held seven focus groups to collect primary data. For quantitative survey data, we summarized descriptive statistics and performed regression analyses to determine predictors of perceived value of the HEART payment. For qualitative focus group data, we coded and analyzed data to understand key themes on success factors and barriers to HEART payment implementation. Principal Findings The HEART payment was rated as high value for 61.3% of survey respondents. In bivariate regression analysis, the level of funds received and affiliation with a Care Transformation Organization (CTO) were associated with perceived value of the HEART payment; however, these associations were not significant in multivariate models. In focus groups, we found that the biggest perceived success of HEART was its unique ability to enable direct support for patients' health-related social needs, with practices using the payment to provide patients with resources such as transportation, medically necessary home remediations, and support for loneliness. Perceived challenges included the need for more precise patient eligibility targeting and administrative burdens. Conclusions The HEART payment is a promising new payment model that enables primary care practices to directly address patients' social needs. Future value-based payment models that incorporate social risk adjustments in

provider payments may consider alternate methods to identify patients with a high burden of health-related social needs. This may include adjusting data points used to identify beneficiaries or allowing providers to directly identify patients.

Why wouldn't I want to go?': doctor migration, retention, return, and Ireland's future medical workforce

HUMPHRIES, N. ET BYRNE, J. P.

2026

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Health workforce shortages pose a challenge to European health systems. Challenging working conditions in healthcare were intensified by the global financial crisis and the coronavirus disease of 2019 (COVID-19) pandemic. In Ireland deteriorating working conditions for hospital doctors triggered a pattern of emigration and an increased dependence on international medical graduates. This article seeks to better understand doctor emigration and its implications for Ireland's future workforce, drawing on the case of Irish doctors who emigrated to Australia. The paper draws on three forms of data: (i) secondary data from the Australian Department of Home Affairs on visas issued to Irish citizen doctors; (ii) open-ended survey responses from hospital doctors working in Ireland (2019, N = 469) and, (iii) qualitative interview data from Irish doctors (2018, N = 51) in Australia. Research ethics permission was granted by the host institution. Significantly more Irish doctors were issued with Australian work visas in 2024 (624) than in 2005 (72). Hospital doctor survey respondents described how emigration decision-making was informed by poor working conditions, inadequate staffing levels, poor wellbeing, and dissatisfaction with the quality of care delivered. Emigrant Irish doctors in Australia indicated that similar issues deterred their return. This article shows that Ireland has high rates of outward and inward doctor migration a limited policy focus on retention or return. Our findings indicate that challenging working conditions are a driver of emigration and a deterrent to return. We call for a more person-centred approach to the medical workforce which would improve doctor working conditions, prioritize their wellbeing and promote retention/return.

Bivariate Copula-Based Regression for Joint Modeling of Healthcare Visits

MARRA, G. ET RADICE, R.

2026

Health Economics 35(2): 332-345.

https://doi.org/10.1002/hec.70059

ABSTRACT Doctor and non-doctor visit frequencies are key indicators of healthcare access, utilization and individual health-seeking behavior. While doctor visits reflect engagement with formal medical services, non-doctor visits, such as to nurses, physiotherapists or alternative providers, offer insights into patient preferences and system adaptability. Modeling these outcomes separately can hide relevant interdependencies and hence lead to incomplete conclusions. To address this, we employ a copula additive distributional regression framework to jointly model doctor and non-doctor visits as flexible functions of demographic, socioeconomic and health-related covariates. The estimation approach allows all the distributional parameters, including location, scale and the dependence structure, to vary with covariates via additive predictors. Application of the model to data from the 2012 Medical Expenditure Panel Survey reveals key determinants of physician and non-physician visits, such as age, income and health status. Importantly, the method allows for the modeling of shared unobserved heterogeneity and effectively captures how changes in one type of utilization influence the other, thereby yielding a deeper understanding of healthcare behavior.

Retention of nurses in the Portuguese NHS: organizational, career, and work–life balance factors shaping intention to stay

MORGADO, M., BEJA, A., MORAIS, R., *et al.*

2026

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https://doi.org/10.1093/eurpub/ckaf232

Nurse retention is a critical challenge across Europe, directly affecting workforce sustainability, quality of care, and health systems resilience. Despite persistent shortages and increasing emigration, evidence on nurse retention determinants within the Portuguese National Health Service (NHS) remains limited. This study aims to identify factors influencing nurses' intention to stay in the NHS, contributing to national and European debates on sustainable workforce strategies. A quan-

titative, observational, cross-sectional survey was conducted among a representative sample of 1494 nurses working in NHS. A validated questionnaire was developed using a Nominal Group Technique and Delphi Panel with stakeholders, to measure job satisfaction with Likert scales. Inferential statistical analyses, including t-tests and multiple linear regression, examined associations between intention to stay and factors such as job satisfaction, work–life balance, career development opportunities, remuneration, and sociodemographic characteristics. Fixed work schedules, overall job satisfaction, age, satisfaction with work-life balance, and career development emerged as significant predictors of intention to stay. Satisfaction with salary and financial incentives, while low, was not statistically significant. Findings highlight the importance of integrated workforce retention strategies combining organizational improvements, career progression pathways, and work–life balance policies. These findings differ from those observed among physicians in parallel research, confirming the need for profession-specific retention approaches. This study provides new evidence on nurse retention in Portugal, reinforcing the need for human resources policies aligned with European Union priorities on workforce sustainability. Cross-country policy learning and evidence-informed, context-sensitive strategies are crucial for supporting nurse retention and health system resilience.

Now What? Neighborhood Nursing's Answer to the US Health Care Paradox of Spending More but Getting Less

NOGUEIRA, A., *et al.*

2025

Milbank Q 103(4): 988-1002.

https://doi.org/10.1111/1468-0009.70063

Policy Points Scalability and policy pathway: The universal access to health and social care provided by Neighborhood Nursing can be sustained by states leveraging existing policy frameworks like States Advancing All-Payer Health Equity Approaches and Development (AHEAD). Trust in health systems: With the United States at a low point for trust in expertise, Neighborhood Nursing can improve community trust in medical expertise using longitudinal relationships with trusted nurses and community health workers. Transformative impact: Neighborhood Nursing offers a framework that integrates multiple governmental levels for expanding health care policy from treatment-focused in health facilities to prevention-focused in people's homes and communities. CONTEXT: Despite spending more per capita on healthcare than any other nation, the United States experiences declining life expectancy and increasing chronic disease burden-a paradox reflecting fundamental limitations in the current treatment-centered, facility-based care system. This paper introduces Neighborhood Nursing, an innovative universal care infrastructure designed to shift the US healthcare toward proactive, prevention-centered care organized geographically in neighborhoods. METHODS: Neighborhood Nursing connects every person within defined geographic areas to interdisciplinary teams of nurses and community health workers who provide promotive, preventive, and restorative services in homes and community hubs. The infrastructure operates in an institutional architecture that integrates activities across three levels: neighborhood services, state-level operational platforms, and a national center supporting research and thought leadership, operational excellence and growth, systems design and evolution, and policy orchestration and advocacy. FINDINGS: Drawing on international evidence-based models like Costa Rica's EBAIS and other community-oriented primary care approaches, Neighborhood Nursing addresses three core challenges in US healthcare: the prioritization of provider expertise over lived experiences, the system's reactive nature focused on treating illness rather than promoting health, and inequitable access that perpetuates mistrust in health systems, especially in marginalized communities. CONCLUSIONS: This paper introduces Neighborhood Nursing, contrasts it with the current US system, examines international precedents, discusses implementation within value-based payment ecosystems, and outlines evaluation approaches for assessing health outcomes, community trust, and system efficiency.

Physician retention in a context of workforce shortages: evidence from Portugal's National Health Service with European policy implications

OSÓRIO, R., MORAIS, R. ET CORREIA, T.

2026

European Journal of Public Health 36(Supplement_1): i28-i33.

https://doi.org/10.1093/eurpub/ckaf239

Physician shortages threaten healthcare system sustainability across Europe. Retaining physicians is critical to maintaining service capacity and quality.

Despite its importance, physician retention remains a pressing issue in Europe, including in Portugal, where the Portuguese National Health Service (NHS) continues to face significant retention challenges. We conducted a quantitative, observational, cross-sectional study to identify determinants of physician retention in Portugal. A validated survey was developed using a Nominal Group Technique and Delphi Panel with stakeholders. The questionnaire measured job satisfaction with Likert scales. A stratified sampling strategy ensured representation across Portugal's five mainland health regions, yielding 1398 physicians. Data were collected via self-administered electronic questionnaires. Analyses included descriptive statistics, ANOVA, t-tests, and linear regression to assess predictors of retention. Physicians with longer seniority reported higher intention to remain, with those over 10 years showing the strongest intention (mean = 3.72; SD = 1.05; P < .001). Fixed schedules were linked to higher intended retention than shift work (mean = 3.42 vs. 3.18; P = .015). Job satisfaction was the strongest predictor (β = 0.267; P < .001), followed by age (β = 0.222; P < .001), satisfaction with work characteristics (β = 0.125; P = .002), and career development (β = 0.097; P = .011). Satisfaction with human resources and work-life balance was not significant. Physician retention is shaped by seniority, schedule stability, work environment, and career development. Policies fostering supportive environments, predictable schedules, and professional growth are needed to sustain the workforce, to European systems.

Improving Collaborative Engagement in Health State Valuation: A Scoping Review of Current Practices and Emerging Recommendations

POWELL, P. A., *et al.*

2026

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Collaborative engagement with individuals invested in or affected by health research, beyond researchers themselves, is advantageous and encouraged by major funding bodies. However, the degree of collaborative engagement in health state valuation is unclear. A scoping review was conducted to (i) identify recommendations on best practice in collaborative engagement in health economics and related literature; (ii) identify examples of collaborative engagement in valuation studies; and (iii) map (ii) onto (i) to identify current practice and future recommendations.

The effects of delayed remuneration on doctor labour supply: Evidence from the English NHS

PROPPER, C., *et al.*

2026

Journal of Health Economics 106: 103119.

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We examine the labour supply response of doctors in England to a reform to public sector pensions that increased the link between current labour supply and pension value. Exploiting the staggered rollout of the reform across narrowly defined birth cohorts, we find that mid-career doctors increased their labour supply to the public healthcare system by just under 4% four years after exposure. This was driven by increases on the extensive margin of working in the public healthcare system. Our results imply an extensive margin labour supply elasticity with respect to the link between current labour supply and pension value of 0.04. Taking into account current pay we estimate an extensive margin labour supply elasticity with respect to total remuneration of 0.29. This is similar to estimates of doctor labour elasticities with respect to pay in other contexts, and suggests that delayed remuneration can be an effective tool for hospital systems to affect mid-career doctor labour supply.

Measuring Primary Care Productivity in the Era of Interprofessional Team Care: Stakeholder, Scoping Review, and Implementation Perspectives

RUBENSTEIN, L. V., *et al.*

2025

Milbank Q 103(4): 1108-1134.

https://doi.org/10.1111/1468-0009.70044

Policy Points The economics and outcomes of modern primary care are substantially driven by investment in interprofessional clinical team members aimed at delivering complex, population health-oriented care. Neither interprofessional primary care team investment nor the work products expected in return are well represented in current commonly used productivity metrics. Stakeholder perspective-guided scoping review followed by expert panel input on measure development showed the feasibility of applying economic methods for assessing primary care productivity relative to multiple high-value products. CONTEXT: Current primary care productivity measures do not account for investment in interprofessional primary

care teams in relation to primary care goals and thus are insufficient for assessing and improving primary care efficiency and productivity. We explored alternative productivity measurement methods. METHODS: We conducted a scoping review of English language literature between 2008 and 2023 to identify articles that assessed primary care practice productivity and efficiency. We reviewed the full texts of articles to assess their analytic models including inputs, outputs, and context measures. Using scoping review results to inform content, we conducted a modified Delphi expert panel to discuss potential use cases, analytic approaches, and data elements for new primary care productivity measures. Panelists anonymously voted on recommendations for guiding near-term measure development and testing. FINDINGS: Evidence review identified 25 included studies. The majority (76%, 19/25) used an economic model-based productivity calculation, predominantly estimated using data envelopment analysis (DEA), with stochastic frontier analysis accounting for most of the remainder. Primary care staffing was the most common input, included in 84% of the 19 economic model studies. As outputs, over half (53%) of studies included measures of quality of care, whereas the same proportion included numbers of clinical activities. No studies used patient-reported experiences of care. Expert panelists recommended that initial measure development focus on primary care practice efficiency improvement, building the measure on routinely collected health system data, accounting for the clinical team's full-time equivalent staffing, and incorporating quality of care. Panelists endorsed DEA while also acknowledging that other approaches had potential. CONCLUSIONS: We identified measurement approaches that aligned with both economic and foundational primary care principles but none that were implemented for routine use. Opportunities exist to develop metrics that accurately reflect primary care structures, goals, and values.

What happens to population health when the doctors leave? Evidence from the exit of Cuban doctors in Brazil

SLIWA RUIZ, S., *et al.*

2026

Journal of Health Economics 106: 103099.

https://doi.org/10.1016/j.jhealeco.2025.103099

This paper studies the effects of a large-scale exit of doctors on population health outcomes, health production inputs, outputs, and health system adaptation in Brazil. Identification exploits the exogenous timing of the Cuban exit from municipalities that relied more versus less on Cuban doctors within the More Doctors Program. We find persistent reductions in the care of chronic diseases, while service utilization for conditions requiring immediate care, such as maternal-related services and infections, quickly recovered. Reductions in utilization did not translate into changes in health outcomes. Supply-side response and demand diversion helped mitigate major adverse repercussions for population health at the market level.

Primary Care Physician Trends: Dissatisfaction, Stress, And Burnout In The US And 9 Comparator Countries, 2012–22

STEINBECK, V., *et al.*

2026

Health Affairs 45(3): 251-260.

https://doi.org/10.1377/hlthaff.2025.00880

Burnout and decreased well-being among primary care physicians threaten workforce sustainability and health outcomes. Understanding how primary care physician burnout and its mitigators differ across countries could inform policy changes, but evidence is limited. Using 2012–22 survey data from primary care physicians in the United States and nine other high-income countries, we found that shares reporting stress rose across countries. By 2022, the US had one of the highest shares of primary care physicians reporting burnout (44 percent). Switzerland (18 percent) and the Netherlands (12 percent) had the lowest shares reporting burnout, alongside higher shares with satisfaction and lower shares with stress. Across countries, female physicians had higher odds of burnout, whereas workplace factors—including satisfaction with income and administrative workload—and better care quality were associated with reduced odds of burnout. Efforts to reduce burnout should address disparities by sex and should include systemic supports including quality initiatives, flexible work, and arrangements for patient cross-coverage; in-depth cross-national learning could reveal additional strategies.

Majority Of Family Physicians Still Choose To Practice In The State Where They Were Trained

TOPMILLER, M., *et al.*

2026

Health Affairs 45(3): 246-250.

https://doi.org/10.1377/hlthaff.2025.01003

Given the recent expansion of US family medicine residency programs, we updated data on the link between training location and practice location and explored its relationship with primary care capacity. We found that most family physicians practice near their residency training programs, and many high-retention states have low primary care physician capacity.

Providing Health Care to People Experiencing Homelessness: Strategies and Challenges for Cross-Sector Initiatives

YEDIDIA, M. J. ET CANTOR, J. C.

2025

Milbank Q 103(4): 1135-1160.

https://doi.org/10.1111/1468-0009.70056

Policy Points Initiatives that effectively bridge health care and housing sectors in serving people experiencing homelessness (PEH) shared four dimensions: success in matching client preferences with readily achievable options, maintaining intensive interaction, initiating outreach where clients are, and co-locating health and housing services. Analyses of accounts of those with firsthand experience implementing cross-sector programs yielded valuable guidance on strategies for incorporating these dimensions. Changes in policies associated with the new federal administration may pose new challenges but are unlikely to alter the relevance of accumulated experience in making use of available resources to effectively engage PEH in health care and housing services. CONTEXT: Cross-sector collaborations among health care and housing services organizations promise more efficient use of resources and delivery of more coherent and effective services to people experiencing homelessness (PEH). This study analyzes challenges and strategies reported by those currently implementing cross-sector programs. METHODS: Data were collected through in-depth interviews with staff of health care and housing services at eight programs systematically selected to typify the scope and nature of cross-sector collaborations in New Jersey. Respondents included administrators (n = 14) and frontline providers (n = 10). Questions focused on motivations to collaborate, approaches to sustaining partnerships and managing operations, mechanisms for financing services across sectors, and strategies for effectively engaging PEH in health care services. Interviews were audio-recorded and inductively analyzed using standard qualitative techniques. FINDINGS: Collaborations were motivated by the impact of housing on health, the ineffectiveness and costs of attempting to address unmet health care needs in the absence of providing shelter, and the promise of harnessing resources from both sectors. Accounts of successful approaches for engaging PEH in health care services had four fundamentals in common: establishing rapport through matching client preferences with readily achievable options, maintaining intensive interaction, initiating outreach where clients are, and co-locating health and housing services. Favored policies for promoting effective implementation included financing case management services through contract or capitation arrangements, resolving ambiguities in licensing regulations and reimbursement practices that impede co-location of services, securing direct financing for delivery of nursing services at shelters, and providing greater support for frontline providers. CONCLUSIONS: The programs' accumulated experiences in successfully implementing cross-sector programs yielded valuable insights for other organizations seeking to mount similar initiatives and for creating a more hospitable policy environment for programs to succeed. Policies of the new federal administration may raise new challenges but are unlikely to diminish the importance of lessons for achieving effective cross-sector collaboration.

Scale, Skill-Mix, and Access Implications of the Production of Appointments by Primary Care Practices in England

ZHAO, T., *et al.*

2026

Health Economics 35(3): 423-438.

https://doi.org/10.1002/hec.70064

ABSTRACT Primary medical care has traditionally been provided by small organisations. Recent policy developments in many countries have encouraged larger practices in the hope of benefiting from increasing returns to scale, but there is little research evidence to support this. Using monthly data from 6149 primary care practices in England between August 2022 and July 2024, we applied a Generalized Linear Model with a logarithmic link and Poisson distribution to examine the relationship between staffing levels and appoint-

ment volumes. At the median level of administrative staffing, the estimated marginal productivity of doctors and other clinical staff on total appointments are 223 and 152 per month, respectively. The marginal effects of all types of staff on appointment volumes increase with staffing levels. We plot the isoquant and isocost curves at the median level of production and examine the implications of our findings for skill-mix and patient access. The current ratios of doctors to other clinical staff and nurses to Direct Patient Care (DPC) staff are lower than cost optimal, though this is less of an issue for larger practices who benefit more from DPC roles. Additional clinical staff improve patient access more when employed in larger practices.

▶ Private Equity Acquisition Of Primary Care Practices: Modest Growth In Clinicians Offset By Increased Clinician Exits

ZHU, J. M., *et al.*

2026

Health Affairs 45(3): 261-268.

https://doi.org/10.1377/hlthaff.2025.01159

Private equity (PE) acquisition of primary care practices has raised questions about the effect on the clinician workforce, a key determinant of care continuity and access. We examined workforce changes after PE acquisition of 451 US primary care practices during the period 2018–22, using a difference-in-differences design with 2,241 matched independent control practices. Outcomes included the number of clinicians per practice and clinician exits, stratified by physician and advanced practice provider status. After acquisition, practices experienced a relative increase of 0.39 clinicians per practice, a 12.2 percent rise from the preacquisition mean of 3.2 clinicians per practice. Growth was observed for both the number of physicians (0.21) and the number of advanced practice providers (0.18). Exits increased by 0.22 clinicians per practice, largely driven by turnover among advanced practice providers. PE acquisition was associated with modest growth and higher advanced practice provider turnover, raising important questions about how ownership influences staffing dynamics in primary care, where workforce stability is critical to patient-centered delivery of care.

Systèmes de santé

Health Systems

▶ Disrupting the information order in health care: Institutions, policy regimes, and the value of data

ANTHONY, D. ET STANHAUS, A.

2026

Social Science & Medicine 395: 119023.

https://doi.org/10.1016/j.socscimed.2026.119023

This study analyzes how U.S. healthcare organizations view regulatory changes to the accessibility of patient health information as part of the 21st Century Cures Act. Rulemaking for the Cures Act recommended a technical change that would enable vendors in the consumer marketplace outside the institutional context and special data protections of health care to gain access to private patient data. We examine organizational stakeholders' comments during the Notice of Public Rulemaking to show how organizational actors both inside and outside of health care use the institutional values and relationships of health care versus the market to evaluate the impact of the technical change. Healthcare insiders use professional ethics and doctor-patient relationships to defend the status quo of data protections in health care. Outsiders, such as consumer health apps, use the logic and relationships of the marketplace to challenge clinical control of patient information as well as data protections and property rights over patient health data. Technical change alone does not alter the information order of health care, but it creates an opening to challenge the existing meaning and management of information and thereby potentially disrupt established institutions in health care in the United States.

Defining and Measuring Organizational Transformation in Health Care: A Systematic Literature Review

CLACK, L., *et al.*

2026

Medical Care Research and Review 83(2): 71-102.
https://doi.org/10.1177/10775587251356130

Organizational transformation in health care is critical to achieving systemic improvements, yet it lacks a cohesive body of empirical literature. Thirty-six articles met inclusion criteria in this systematic literature review of empirical studies of whole-organization transformation describing the transformation process and measures of transformation. Studies had diverse analytic (n = 14) and descriptive (n = 22) aims and were published in many different journals. Few articles provided definitions of transformation. Most employed weak research designs, about half used models for evaluation, and no common measures of transformation were used across articles. Combinations of distributed leadership, staff engagement, and culture change were recurring themes contributing to successful transformation. Two-thirds of articles used models to guide the transformation process. There was no consistency across articles in which models were used for evaluating or guiding change. Most articles reported successful transformation. The literature is methodologically weak, highlighting the need for more rigorous, theory-driven research on health care transformation.

National Health Care Spending Increased 7.2 Percent In 2024 As Utilization Remained Elevated

HARTMAN, M., *et al.*

2026

Health Affairs 45(2): 110-120.
https://doi.org/10.1377/hlthaff.2025.01683

Health care spending in the US reached $5.3 trillion and increased 7.2 percent in 2024, similar to growth of 7.4 percent in 2023, as increased demand for health care influenced this two-year trend. As in 2023, the use and intensity of health care goods and services continued to grow rapidly in 2024, particularly for hospital care, physician and clinical services, and retail prescription drugs. The insured share of the population remained relatively high in 2024, at 91.8 percent, after its peak in 2023 of 92.5 percent. Health care spending growth continued to outpace overall economic growth in 2024, and as a result, the health care share of the economy increased from 17.7 percent in 2023 to 18.0 percent in 2024.

Nationwide Consequences, Rural Devastation: The Unequal Toll of Public Health Spending Reductions

LEIDER, J. P., *et al.*

2026

Journal of Health Politics, Policy and Law 51(2): 309-327.
https://doi.org/10.1215/03616878-12262656

This article examines the implications of recent and proposed reductions in federal public health funding with a focus on how these cuts disproportionately impact rural and low-resource communities. Drawing insight from national datasets, the authors document the increasing reliance of state and local public health systems on federal funds, particularly in the aftermath of COVID-19. Scenario modeling reveals that a rollback to pre-COVID federal funding levels would likely leave many local jurisdictions unable to sustain core public health services, especially where local fiscal capacity is limited. The authors argue that, while some communities may be able to partially offset federal losses with local revenues, most lack the means to do so at scale, particularly in rural areas already strained by limited infrastructure. This article offers empirical estimates of federal support, evaluates the plausibility of local revenue substitution, and analyzes the consequences of federal disinvestment for the Foundational Public Health Services. These findings underscore a key tension in federalism in which calls for local autonomy amid shrinking federal support risk exacerbating health inequities and eroding core protections, both of which lead to critical questions about the federal government's role and responsibility in ensuring a resilient and equitable public health system.

Exploring State-Level Change in Health Care Value Over Three Decades in the United States, 1991–2020

LESCINSKY, H., *et al.*

2026

Health Services Research 61(1): e70054.
https://doi.org/10.1111/1475-6773.70054

ABSTRACT Objective To examine trends in state-level health care value over three decades, defined using statewide health care spending and cause-specific

mortality, and to explore its associations with potentially modifiable state attributes. Study Setting and Design We use stochastic frontier analysis to identify the "inefficiency" of each state's delivery system in converting health care spending into lower mortality–incidence or mortality–prevalence rates, adjusting for underlying population risk (age, smoking, obesity, etc.). We combine these inefficiency scores to score and compare delivery system value for each state and track change over three decades. Then, we use linear regression to look across states and identify state-level attributes significantly associated with greater health care value. Data Sources and Analytic Sample For each US state and year from 1991 to 2020, we extracted mortality–incidence or mortality–prevalence rates for 67 high-mortality health conditions from the Global Burden of Disease 2021 Study and state health care spending from the State Health Expenditure Accounts. Principal Findings Across US states, value on average increased from 1991 to 2000, remained relatively constant from 2001 to 2010, and then declined from 2011 to 2020 by 16.7% (95% uncertainty interval [UI]: 14.7–20.1) or 13.6 (95% UI: 11.3–15.9) value points. The percentage of state populations with insurance was positively associated with health delivery system value. In contrast, market consolidation among hospitals and among health insurers of small and large groups, and increased for-profit hospital ownership were each associated with a lower health care value. The net effect of these associations was a reduction in the national value score for the decade ending in 2020. ConclusionsIn contrast to the prior two decades, health care delivery system value scores declined over the last decade. This decline was associated with reduced competition among hospitals and health insurers, increased for-profit hospital ownership, and was partly mitigated by wider insurance coverage.

Public Health Under Siege

OBERLANDER, J. ET GOLLUST, S. E.

2026

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American public health is in crisis. The second Trump administration has imposed sweeping budget cuts and staff layoffs on federal health agencies, eroded the nation's public health infrastructure, and pursued myriad policies that imperil population health both in the United States and across the world. Why is public health under siege, and what does this tumultuous moment reveal about the politics of public health? This article chronicles the damage to public health caused by the Trump administration; analyzes the sources of public health's current predicament, including rising partisan polarization, the COVID-19 backlash, and a shifting political environment; and explores the challenges that lie ahead if public health is to surmount the turmoil that now engulfs it.

Social policies, health systems, and care delivery: Policy implications of eight papers in empirical health economics

SEGHIERI, C., *et al.*

2026

Health Policy 165: 105547.

https://doi.org/10.1016/j.healthpol.2025.105547

Integrated care in the Baltic countries over a five-year period: an expert-informed cross-country analysis of progress, challenges and future directions

SHUFTAN, N., *et al.*

2026

Health Policy 166: 105526.

https://doi.org/10.1016/j.healthpol.2025.105526

Background In Estonia, Latvia, and Lithuania, the push for care integration has gained momentum, being seen as an innovative approach to allocate resources more efficiently and improve patient outcomes. Objective This study investigates the progress of integrating care in the Baltic countries from 2019 to 2024 to detail key learnings. Methods We undertook a cross-country study to better understand the progress in care integration in the Baltics with a two-round, 21-item questionnaire on the adoption of integrated care reforms in 2019 and 2024. Responses were analyzed to capture countries' policy environments and their conduciveness to the uptake of integrated care. Country-specific experiences with implementation of care were further explored via case studies of pilot programmes. Results The pace of implementing integrating care varied. Existing barriers, workforce challenges and payment schemes have impeded integration across health and social care. Despite this, political commitment across successive governments to new and innovative service delivery and collaboration for chronic care management underscores an important prerequisite toward achieving more integrated and person-centred healthcare. The

three case studies illustrate hurdles that come with shifting care settings and expanding roles for some workers. Conclusions Integrating care across providers and the social and health sectors is an incremental process that needs long-term political support to address persistent barriers. The Baltic countries' experiences indicate challenges in bringing together stakeholders in areas such as data interoperability, new financing models and reorganization of workforce and skills mixing. Further work should advance evidence on patient-centred solutions for evolving needs.

The relationship between trust and compliance in the Italian NHS: Results of the People's Voice Survey

TARRICONE, R., *et al.*

2026

Health Policy 165: 105544.

https://doi.org/10.1016/j.healthpol.2025.105544

Background Public health systems are assessed not only for outcomes but also for their ability to sustain legitimacy and trust. Trust supports long-term cooperation, while mandates can secure immediate adherence but risk eroding trust and weakening future willingness to comply. Italy illustrates this paradox, combining strong outcomes and extensive COVID-19 mandates with comparatively low public confidence. Objective To examine how trust, compliance, and intention to comply interact in the Italian health system, in the context of policies that rely on obligation rather than persuasion. Methods We analyzed data from the People's Voice Survey conducted in Italy on a representative sample of 1001 adults. Outcomes were trust in the National Health Service, compliance with COVID-19 vaccination, and intention to comply with future directives. Determinants included perceptions of public influence, trust in scientists, vaccine attitudes, and past healthcare experiences, with education and income as moderators. Results Trust in the NHS was predicted by public influence, trust in scientists, and positive experiences, while negative experiences reduced it. Compliance was driven mainly by vaccine attitudes, with negative experiences lowering adherence. Intention to comply was associated with both general and policy-specific beliefs. Education moderated the role of trust in scientists, and income shaped the effect of experiences. Conclusions Trust sustains future cooperation, whereas reliance on obligation may erode it even in high-performing systems. Policies should foster transparency, responsiveness, and patient experience, and strengthen education as a stable foundation, since mandates ensure short-term adherence but not long-term cooperation.

Travail et santé

Occupational Health

Disability Insurance as a Complement to Labor Income: Evidence From Italian Administrative Data

FRANCESCA, Z., *et al.*

2026

Health Economics 35(4):638-652.

https://doi.org/10.1002/hec.70072

ABSTRACT We investigate how disability insurance (DI) generosity affects DI take-up and labor market participation in a setting where benefits can be cumulated with substantial labor earnings. Using rich administrative data on Italian private-sector workers and a Regression Discontinuity in Time design, we find a large behavioral response to DI generosity, with an elasticity of 1.26 in DI take-up, while employment effects are minor and concentrated among immigrants. Our identification strategy exploits a major social security reform that reduced the expected DI replacement rate and generated a clear income effect. To address unobserved heterogeneity and the unobservability of underlying disability, we focus on individuals affected by acute cardiovascular shocks whose DI eligibility is plausibly exogenous. Overall, our results suggest that when earnings cumulability is extensive, DI is widely perceived as a complement to labor income. This has important implications for the design of labor-inclusive DI schemes.

Effects of Long-Term Exposure to the Earned Income Tax Credit on Work Disability in Later Life

JAJTNER, K., *et al.*

2025

Health Economics 35(4). 638-652
https://doi.org/10.1002/hec.70068

ABSTRACT This study investigates the impact of the Earned Income Tax Credit (EITC) on work disability and Social Security Disability Insurance (DI) claims among Americans. Utilizing the Panel Study of Income Dynamics, we examine the effects of EITC exposure from birth to mid-adulthood on work disability risk before retirement. Our analysis reveals that EITC exposure during adulthood significantly reduces the likelihood of work disability, potentially influencing DI trends. Specifically, a $10,000 increase in cumulative EITC exposure is associated with about a 1.25 percentage-point lower probability of any work limitation at ages 50–61 (a 0.94 percentage-point reduction in the likelihood of chronic/severe limitations) and a 0.84 percentage-point reduction in DI receipt, highlighting the EITC's potential role in reducing DI dependency and its broader implications for public policy and social welfare.

Shift work and risk of chronic kidney disease: A systematic review and meta-analysis

JUNG, J., *et al.*

2026

Social Science & Medicine 394: 119055.
https://doi.org/10.1016/j.socscimed.2026.119055

Objectives This systematic review and meta-analysis is aimed to critically evaluate and quantify the association between shift work and chronic kidney disease (CKD). Methods We searched PubMed, Embase, and Web of Science through May 2025 for observational studies examining shift work—including night or rotating shifts—and CKD outcomes among adults. Eligible outcomes included reduced estimated glomerular filtration rate (eGFR), proteinuria, or albuminuria. Study quality was assessed using the Newcastle–Ottawa Scale, and meta-analyses were performed where feasible. Results Twelve studies were included in this systematic review. Most studies defined CKD as eGFR below 60 mL/min/1.73 m2 or presence of albuminuria, although outcome definitions varied. Meta-analysis of 6 studies found that shift workers had significantly higher odds of CKD (pooled odds ratio: 1.43; 95% CI: 1.06–1.92) compared to non-shift workers. Risk of bias was moderate to low across studies. Heterogeneity was modest, and no significant publication bias was detected. Conclusions Shift work is associated with a modestly increased risk of CKD. Circadian disruption and related metabolic disturbances may underlie this relationship. Given the widespread prevalence of shift work and the global burden of CKD, these findings support the need for targeted occupational health surveillance and preventive strategies for shift-working populations.

Elucidating the role of unemployment in complex social inequalities in mental health: An intersectional mediation analysis of the cross-sectional Spanish National Health Surveys

MORENO-LLAMAS, A., *et al.*

2026

Social Science & Medicine 393: 119041.
https://doi.org/10.1016/j.socscimed.2026.119041

Women, migrants and those in manual occupations face barriers in the labor market and are more vulnerable to unemployment, which in turn may impact mental health and contributes to inequalities. Previous research has not considered the intertwinement of multiple inequalities. This study examined intersectional inequalities (intersecting gender, social class, and migration status) in poor mental health and the mediation role of unemployment in the Spanish adult population, using the 2012 and 2017 cross-sectional Spanish National Health Surveys (n = 22,383, 18–64 years, response rates: 89.6 % and 74.0 %). Mental health was measured using the GHQ-12 and classified into good and poor. Unemployment was classified as employed or unemployed. Gender (men or women), social class (manual or non-manual) and migration status (born in Spain or migrant) were cross-classified in eight intersectional strata. Intersectional mediation analysis showed that, compared to non-manual native men, poorer mental health was found in women, migrants and manual occupations (total effect). Unemployment completely mediates mental health inequalities in strata of men with manual occupations but partially in strata of women. Moreover, mental health inequality was explained by both higher unemployment prevalence (pure indirect effect) and by greater vulnerability to unemployment (mediated interaction effect) among native men and women in manual occupa-

tions and immigrant women in non-manual occupations compared to non-manual native men. In conclusion, complex mental health inequalities seem to be underpinned by the dual processes of higher risks and worse consequences of unemployment. Health policies should target strata of manual occupations since they were more likely to be unemployed.

Waiting times for health services, health, and labour market outcomes

SICILIANI, L.

2026

European Journal of Public Health 36(Supplement_2): ii3-ii7.

https://doi.org/10.1093/eurpub/ckaf213

Waiting times for health care is a significant health policy concern across many health systems, which has been exacerbated by the COVID-19 pandemic. Long waiting times for non-emergency care generate health losses to patients because health benefits are postponed. They can increase the risk of mortality or morbidity and reduce patient ability to benefit from health care. Waiting times can also generate negative spill-over effects on labour market outcomes. For individuals in the working age, employed individuals might end up on sick leave and claim sickness benefits, or experience reduced productivity if they continue to work. Individuals looking for a job may find it harder to find employment or become economically inactive. We conduct a narrative review of the literature on the effect of waiting times on health losses and labour market outcomes. There is growing literature documenting the effect of longer waiting times on labour market outcomes. Although limited, the literature identifies potentially harmful effects in particular when patients are waiting for mental health services and orthopaedic treatment. The findings have implications for prioritization of patients on the list and for allocation of resources within the health sector and across sectors.

Vieillissement

Ageing

The Generational Gift: The Effects of Grandparental Care on the Next Generations' Health and Well-Being

BARSCHKETT, M., *et al.*

2026

Health Economics 35(3): 522-547.

https://doi.org/10.1002/hec.70054

ABSTRACT Health and well-being in the family context can be affected by care giving arrangements. Following parental care and daycare, grandparents are the third most important care givers for children in many Western societies. Despite the relevance of grandparental care, there is little evidence on the causal effects of this care mode on the next generations' health and well-being. In this paper, we fill this gap by investigating the causal impact of regular grandparental care on the self-reported health and (domain-specific) satisfaction of both parents and children. To do so, we exploit geographic distance to grandparents as a source of arguably exogenous variation and use representative German panel data for families with children under the age of 11. Our results suggest positive effects on parental satisfaction with the child care situation, as well as mothers' satisfaction with their leisure time. However, we also find negative effects on children's health, particularly for elementary school aged children and for boys.

Staffing Conditions In US Nursing Homes Before, During, And After The COVID-19 Pandemic

BHAUMIK, D., *et al.*

2026

Health Affairs 45(2): 193-199.

https://doi.org/10.1377/hlthaff.2025.00570

The COVID-19 pandemic exacerbated long-standing challenges in US nursing homes around staffing conditions, with nearly one in five nursing homes reporting severe staffing shortages during the early months of the pandemic in 2020. However, less is known about how nursing home staffing has evolved since the early

part of the pandemic. This study used Payroll-Based Journal daily staffing data from the second quarter of 2018 through the fourth quarter of 2024 and other administrative data to examine trends in nursing home staffing levels and turnover before, during, and after the COVID-19 pandemic. Since the start of the pandemic, staffing hours per resident day decreased for all nurse types, especially in nursing homes associated with private equity funds or real estate investment trusts, during the late pandemic and postpandemic periods. Staff turnover decreased slightly during the pandemic and postpandemic periods for all nurse types. Policy makers should consider additional measures to ensure appropriate nursing home staffing levels going forward.

Incidence of dementia diagnosis in Denmark, 1986–2023: an age-period-cohort analysis

CALLAWAY, J., *et al.*

2026

Social Science & Medicine 392: 118951.

https://doi.org/10.1016/j.socscimed.2026.118951

Denmark is experiencing unprecedented population ageing, highlighting the importance of understanding age-related diseases, including dementia. Dementia is a syndrome characterised by progressive decline in cognitive function that interferes with daily activities and independent living. This study quantifies changes in dementia diagnosis across ages, time periods, and birth cohorts in Denmark. Using Danish registry data from 1986 to 2023, we analysed all individuals aged 50 and older, corresponding to the birth cohorts 1886–1973. We conducted an age-period-cohort analysis and stratified by sex. Dementia diagnosis was measured by either: 1) hospitalisation for dementia via ICD codes; or 2) filling at least two prescriptions for a dementia-related drug. Dementia diagnoses increased with age across cohorts and periods. The age effect showed rates beginning to rise around age 75 and peaking in the late 80s and early 90s. Looking at the period effect, incidence rates begin to increase in 1997 when the first dementia-related drugs became available, followed by a decrease in later years. Younger cohorts showed lower dementia incidence rates compared to older cohorts at similar ages, likely due to changes to modifiable risk factors. Findings from this study contribute to understanding dementia risks on the age, period, and cohort levels, and can inform public health policies aimed at diagnosing cognitive decline and improving quality of life for older populations.

Nursing Homes as Insurers? The Effect of Provider-Led Institutional Special Needs Plans

CHEN, A. C., *et al.*

2026

Health Services Research 61(1): e70067.

https://doi.org/10.1111/1475-6773.70067

ABSTRACT Objective To estimate the effect of starting a provider-led Institutional Special Needs Plan (I-SNP) arrangement on facility-level enrollment, utilization, and quality. Study Setting and Design I-SNPs are a type of Medicare Advantage (MA) plan that allows insurers to differentiate their benefits exclusively for long-term residents in nursing homes. Since I-SNPs first became available in 2006, there has been growth in provider-led I-SNPs where nursing homes are financially integrated or partnered with an insurer to operate a plan for their own residents. We used a difference-in-differences design to estimate the effect of starting a provider-led I-SNP arrangement on several facility-level outcomes, including the share of a facility's long-stay residents who were enrolled in an I-SNP, hospitalizations, medication use, pressure ulcers, physical restraints, falls, and mortality. Data Sources and Analytic Sample We used Medicare claims and nursing home resident assessments (2004–2021) to identify Medicare long-stay nursing home residents. Principal Findings The start of a provider-led I-SNP arrangement led to a 17.0 percentage point (pp) increase (standard error [SE]: 0.006) in I-SNP enrollment among facility residents within 4 years relative to control nursing homes. We also estimate that the start of a provider-led I-SNP arrangement significantly decreased hospitalizations (−1.0 pp, SE: 0.002), increased the use of antipsychotic (0.4 pp, SE: 0.002) and hypnotic drugs (0.3 pp, SE: 0.001), and reporting of pressure ulcers (0.4 pp, SE: 0.002). Conclusions Provider-led I-SNPs allow nursing homes to bear financial risk for their residents. These results suggest that this form of risk bearing may successfully reduce utilization (e.g., hospitalizations), but with unclear implications for quality as increased use of sedating drugs and rates of pressure ulcers could either reflect poorer care or retention of sicker patients due to lower hospitalization rates.

The Effects of Wealth Shocks on Public and Private Long-Term Care Insurance

COSTA-FONT, J., *et al.*

2026

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https://doi.org/10.1016/j.jhealeco.2025.103086

The financing of long-term care services and supports (LTSS) relies heavily on self-insurance in the form of housing or financial wealth. Exploiting both local market variation in housing prices and individual-level variation in stock market wealth from 1996 to 2016, we document that exogenous wealth shocks significantly reduce the probability of LTCI coverage, without significantly altering Medicaid eligibility among owners of housing and financial assets. The effect of shocks to liquid wealth strongly dominates the effect of housing wealth changes. A $100K increase in housing (financial) wealth reduces the likelihood of LTCI coverage by 1.24 (3.22) percentage points.

Predictors of avoidable and unavoidable hospital admissions in older adults: a 15-year population-based cohort study

GENTILI, S., *et al.*

2026

European Journal of Public Health 36(1): 49-55.

https://doi.org/10.1093/eurpub/ckaf264

We examined sociodemographic, clinical, and functional characteristics influencing avoidable and unavoidable hospital admissions in older adults over 15 years. The study included 3166 participants aged 60+ years from the Swedish National Study on Aging and Care in Kungsholmen. Hospital admissions were identified through national registers and classified as avoidable using official Swedish criteria. Multistate models estimated hazard ratios (HRs) and 95% confidence intervals (CIs) for both admission types. During the 15-year follow-up, the incidence rates of avoidable and unavoidable hospital admissions were, respectively, 5.74 and 35.17 per 100 person-years. Avoidable admissions due to chronic conditions were more common than those due to acute conditions (3.94 vs. 1.80 per 100 person-years over 15 years). Women had lower risk of both avoidable and unavoidable admissions compared to men (HRs range 0.46–0.76), while being unpartnered increased the risk for both hospitalization types (HRs range 1.13–1.33). Receiving formal care lowered the risk of unavoidable admissions (HR 0.78, 95% CI 0.73–0.84), whereas informal care increased the likelihood of avoidable admissions due to chronic condition (HRs range 1.17–1.34). Multimorbidity, slow gait speed, and polypharmacy associated strongly with avoidable admissions (HRs range 1.41–2.50). Conversely, cognitive impairment and disability lowered risk of avoidable admissions for chronic conditions (HRs range 0.62–0.83). Multimorbidity, slow gait speed, and polypharmacy predicted higher risks for avoidable admissions from chronic conditions, while disability and cognitive impairment showed lower risks. These findings underscore the need for timely and comprehensive evaluation strategies to reduce the burden of avoidable hospital care.

L'autonomie entre discours hégémonique et action publique. Les débats à l'Assemblée nationale sur l'allocation personnalisée d'autonomie en 2001

GIRAUD, O. ET REBOURG, M.

2025

Revue des politiques sociales et familiales 155(3): 85-101.

https://doi.org/10.3917/rpsf.155.0085

L'article analyse la dynamique de définition de la notion d'autonomie dans les débats lors du vote au Parlement français de la loi sur l'allocation personnalisée d'autonomie (Apa) de 2001. Alors que les rapports préparlementaires et le discours gouvernemental mettaient en avant une définition de l'autonomie centrée sur l'égalité et l'émancipation des personnes, le projet de loi déposé par le gouvernement en mars et le texte voté en juillet ont fixé une définition capacitaire de l'autonomie. Elle suppose l'encadrement des choix des personnes âgées par des commissions administratives et sociomédicales et n'affronte pas la question des inégalités territoriales. Cet article analyse les débats parlementaires autour de la loi de 2001 pour éclairer ce paradoxe et montre que les concepts de « discours hégémonique », à vocation universelle, et d'« *empty signifier* » (ou « signifiant vide ») s'appliquent au discours associant l'autonomie à l'égalité et à l'émancipation, promues par le gouvernement. Autour de six enjeux spécifiques traités par la loi et organisant concrètement l'accès des personnes à des mesures censées les soutenir dans leur autonomie, cette étude révèle les réussites et les limites du discours hégémonique dans le contexte de ce processus parlementaire.

Trends in Long-Term Care Ombudsman Program Funding and Its Relationship to Nursing Home Resident Care

KENNEDY, K. A., *et al.*

2025

Milbank Q 103(4): 1204-1223.

https://doi.org/10.1111/1468-0009.70061

Policy Points Funding that states' Long-Term Care Ombudsman Programs (LTCOPs) receive must cover all activities in that state related to the care of all individuals in nursing homes (NHs) and board and care (i.e., residential care communities, assisted living, and similar care homes); over time, duties and demands have expanded without similar increases in funding. States are contributing more to their federally mandated LTCOPs than they have historically. Evidence from this study suggests that increased spending on LTCOPs is associated with improved NH resident care, supporting the National Academies of Sciences, Engineering, and Medicine's recent call for increased funding to LTCOPs. CONTEXT: Funded partially by the Older Americans Act, state Long-Term Care Ombudsman Programs (LTCOPs) provide a critical role in serving as advocates for older adults in long-term care (LTC) facilities. Ombudsmen regularly visit residents, resolve disputes, and assist with discharge planning. In 2022, the National Academies of Sciences, Engineering, and Medicine called for increased LTCOP funding to improve nursing home (NH) quality. However, it is unclear how changes in program funding are associated with the care provided to NH residents. Based on the functions that the LTC Ombudsmen are intended to provide, we hypothesized that increases in LTCOP spending would be associated with improved care in NHs. METHODS: We examined 20-year trends in funding for the LTCOP (2000 to 2019). Using 2011-2019 data from the National Ombudsman Reporting System, LTCFocus.org, Centers for Medicare & Medicaid Services Care Compare, and the Area Health Resource File, we examined the relationship between LTCOP spending per LTC bed at the state level and NH outcomes, controlling for year, state, facility, and market characteristics. FINDINGS: Overall, LTCOP funding increased over 20 years. However, the share of federal contributions to the LTCOP has decreased from 58.8% in 2000 to 46.9% of the total program's budget in 2019. The LTCOP spent an average of $37.30 per LTC bed in 2019, with wide state variation. In 2011, the average share of residents receiving antipsychotics was 25.4%, the share of those who were physically restrained was 2.9%, and the share of those with low-care needs was 13.5%. For every $100 annual increase in total spending per bed, there was a statistically significant 1.32, 1.13, and 2.95 percentage-point decrease in the share of residents receiving antipsychotics, those who were physically restrained, and those who with low-care needs, respectively. CONCLUSIONS: States that have increased funding for their LTCOP observe better NH resident care. These findings support calls to increase funding for LTCOPs.

Clinician Specialization in Skilled Nursing Facility Practice and Post-Acute Outcomes of Patients With Dementia

KIM, S., *et al.*

2026

Health Services Research 61(1): e70035.

https://doi.org/10.1111/1475-6773.70035

ABSTRACT objective To evaluate the effects of physician and advanced practitioner specialization in skilled nursing facility (SNF)-based practice (SNFists) on the outcomes of patients with Alzheimer's disease and related dementias (ADRD) admitted to SNF for post-acute care. Study Setting and Design Taking advantage of the natural experiment provided by the growth of SNFists, we conducted a within-SNF difference-in-differences analysis with cross-temporal matching. Our primary outcome was functional improvement at SNF discharge, measured using a validated activities of daily living (ADL) score. Secondary outcomes included unplanned rehospitalization, emergency department (ED) visits, observational stays within 30 days of SNF admission, successful discharge to the community, SNF length of stay, admission into long-term nursing home care within 6 months of SNF discharge, and 30- and 60-day Medicare payments for professional and facility services. Data Sources and Analytic Sample Medicare facility and professional claims and Nursing Home Minimum Data Set (MDS) data from 2012 and 2019 were used. The study sample included 338,574 community-dwelling fee-for-service Medicare beneficiaries with ADRD, age 65 or older, discharged from an acute care hospital to one of the 5196 SNFs that experienced an increase in patients treated by SNFists. Principal Findings We did not observe an association between SNFist care and patient post-acute care outcomes or costs. Conclusions Specialization in SNF-based practice among physicians and advanced practitioners alone may not be an effective strategy to improve post-acute care outcomes or reduce costs to Medicare for patients with ADRD.

Predicting Risk of Long-Term Institutionalization Among Community Dwelling Veterans Before the COVID-19 Pandemic

KINOSIAN, B., *et al.*

2026

Health Services Research 61(1): e70016.
https://doi.org/10.1111/1475-6773.70016

ABSTRACT Objective To identify risk of long-term institutionalization (LTI) among Veterans receiving care in the Veterans Health Administration (VA). Study Setting and Design We developed the "Predicted Long-term Institutionalization" (PLI) risk model for Veterans alive in the community at the end of fiscal-year (FY) 2017 followed for LTI in nursing home (cumulative NH days allowing any acute care and up to 7 days in community > 90 days) during FY2018-FY2019. Data Sources and Analytic Sample PLI used demographics, diagnoses, prior hospital and nursing home (NH) use, and risk indices for death and frailty from VA and Medicare claims and Minimum Data Set data. Development of PLI used multiple iterations to maximize sensitivity, constrained by achieving a number needed to screen (≤ 8), including age normalization to minimize algorithmic bias. We combined the elevated risk (ER) and common risk (CR) strata-specific predictions from the logistic regression models to identify three tiers of PLI: low risk, moderate risk, and high risk. We describe Veterans' outcomes in FY2018/2019 (LTI, death, hospitalization and VA cost) across the three PLI tiers. Principal Findings For identifying Veterans in LTI, compared to a baseline model that used only VA data as predictors (sensitivity 23%, specificity 98%), calibrating separate ER and CR strata increased sensitivity to 30%, the addition of Medicare data increased sensitivity to 33%, and age-normalization with differential risk strata thresholds increased sensitivity to 41% (specificity 96.6%). The final PLI model (c-statistic = 0.87) identified 3.5% of Veterans in PLI-high risk (13% LTI rate), who accounted for 41% of new LTI, 22% of decedents, 19% of VA cost, and 11% of hospitalizations in FY2018–2019. Conclusions The PLI score identifies Veterans at high risk of LTI for further assessment and targeting of resources to support continued community residence.

Memory trajectories by migration status and gender: A life-course intersectional perspective

LOI, S., *et al.*

2026

Social Science & Medicine 391: 118885.
https://doi.org/10.1016/j.socscimed.2025.118885

This study explores the relationships between migration, gender, and memory trajectories over the life-course within an intersectional framework. Memory is an important dimension of cognitive decline, a critical concern in aging populations, and varies significantly across different demographic groups. In this paper we address the understudied influence that the intersection of gender and migration status has on memory trajectories and evaluate the role of age at migration. Using random-effects growth curve models, our findings reveal persistent memory disparities by migration status, particularly in early older age, though differentials by migration status generally reduce after age 70. Immigrants, overall, exhibit lower baseline memory functioning levels and steeper declines. Contrary to expectations, immigrant women are not uniquely vulnerable; instead, gender differences persist across groups, with men generally faring worse. Later age at migration predicts poorer memory performance, though a late-life advantage emerges for men who migrated at ages 6–17 warranting further investigation. These results underscore the importance of considering baseline levels, longitudinal patterns, and intersectional factors in cognitive aging research by migration status.

The impact of education on dementia: Evidence from compulsory schooling reforms in England

MONNET, N., *et al.*

2026

Social Science & Medicine 395: 119071.
https://doi.org/10.1016/j.socscimed.2026.119071

Compulsory schooling laws introduced across Europe in the 20th century aimed to expand educational attainment and may have shaped key determinants of cognitive health. We exploit variations in compulsory schooling laws in England to assess whether increased education, mandated by these policies, impacts cognitive function, dementia risk, and related risk factors in older age. We focus on two major reforms: the 1947 reform, which raised the school-leaving age from 14 to

15, and the 1972 reform, which increased it to 16. Using data from the English Longitudinal Study of Ageing (ELSA) and a novel dementia risk algorithm based on the Harmonized Cognitive Assessment Protocol (HCAP), we find that while both reforms increased schooling, their effects on cognitive aging differ. We find suggestive evidence that the 1947 reform improved cognitive outcomes and reduced dementia and mild cognitive impairment risk specifically for women and individuals from low parental education backgrounds. In contrast, we find no statistically detectable reductions in dementia risk associated with exposure to the 1972 reform. Our findings suggest that the impact of compulsory schooling laws on cognitive aging and dementia is context dependent. Findings highlight the importance of institutional context and heterogeneity when assessing the long-run effects of education policies.

The gendered landscape of informal caregiving: Cohort effects and socioeconomic inequalities in England

PETRILLO, M., *et al.*

2026

Social Science & Medicine 393: 119052.

https://doi.org/10.1016/j.socscimed.2026.119052

We provide the first detailed cohort analysis of the gender care gap that examines the association between caregiving provision, individual-level poverty, meso-level deprivation, and individual circumstances. Using data from the UK Household Longitudinal Study, we use (i) multilevel mixed-effects logistic regression to provide a detailed age cohort analysis of the probability of providing informal care by sex; and (ii) Multilevel Analysis of Individual Heterogeneity and Discriminatory Accuracy (MAIHDA) to provide an intersectional examination of informal carers. Our results reveal a clear age pattern in caregiving, peaking between ages 60–70 before declining, with earlier-born cohorts showing higher caregiving likelihood at the same ages than later-born cohorts. The gender care gap is most pronounced among middle-born cohorts (1969–1978, 1959–1968, and 1949–1958), particularly between ages 50 and 60. While overall caregiving prevalence is higher among individuals experiencing poverty and living in deprived areas, the gender care gap is larger among individuals above the poverty line and in non-deprived areas. Caregiving is primarily associated with the independent effects of cohort, gender, poverty, and meso-level deprivation, with limited evidence of multiplicative intersectional effects. Policy attempts to address the gender care gap need to be mindful of these variations, not least because they potentially elucidate the potential sources of gender inequalities in care.

Community-Entry Home Health Made Up Nearly Half Of Home Health Episodes And Spending In Traditional Medicare, 2017–21

SALANT, I., *et al.*

2026

Health Affairs 45(1): 84-91.

https://doi.org/10.1377/hlthaff.2025.00318

Medicare home health care is often characterized as a postacute care benefit, yet community-entry users—those admitted without a preceding hospitalization—account for nearly half of all spending and episodes in traditional Medicare. Using Medicare administrative data from 2017, 2019, and 2021, we analyzed differences between community-entry and postacute home health users. Community-entry beneficiaries were older; were more likely to be dually eligible; and had substantially higher rates of cognitive impairment, Alzheimer's disease, and depression compared with postacute users. Despite these clinical differences, visit patterns remained similar between groups. We documented significant state-level variation in community-entry prevalence, with changes in community-entry share that were positively associated with changes in overall home health spending. Our findings reveal a fundamental tension between policies that favor postacute care and the reality of Medicare home health use, which serves a substantial population with clinical and demographic profiles that differ from those of postacute care users.

Bridging the Hearing Divide: Policy Solutions for Aging Americans

SWAMY, M. R., *et al.*

2026

American Journal of Public Health 116(3): 387-396.

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Hearing loss affects approximately two thirds of adults in the United States aged 70 years or older and frequently remains untreated despite its well-documented harms, including accelerated cognitive decline, increased caregiver burden, and higher health care expenditures. We examine the major barriers to

accessing high-quality hearing care, with particular attention to the complex and fragmented landscape of insurance coverage across Medicare, Medicaid, the US Department of Veterans Affairs, private plans, and over-the-counter (OTC) products. We review key legislative and regulatory developments over the past decade, most notably the 2022 establishment of OTC hearing aids, and summarize early opportunities and remaining gaps. We then propose targeted reforms to improve access and affordability, including more consistent Medicaid benefits, selective Medicare expansion, integration of teleaudiology, and strengthened oversight and consumer protections for OTC devices. Finally, we advance a technology-driven policy framework that integrates artificial intelligence–supported risk prediction, teleaudiology, real-time insurance verification, and a transparent device marketplace to modernize delivery and evaluation. Together, these strategies can catalyze a fundamental rethinking of how hearing health is prioritized and managed within the broader United States health care ecosystem. (Am J Public Health. 2026;116(3):387–396. https://doi.org/10.2105/AJPH.2025.308298)

State Nursing Home Minimum Staffing Mandates: Increased Staff Levels, Minimal Impact On Finances And Closures, 2010–23

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Higher levels of direct care staffing in nursing homes improve resident outcomes, yet concerns persist that minimum staffing mandates could strain facility finances or lead to closures. Using longitudinal data from the period 2010–23 on 6,849 nursing homes operating across twenty-two states, we estimated the effects of state minimum staffing mandates on staffing levels, financial health, and closures. Staffing mandates increased total direct care staff by 0.18 hours per resident day, or roughly 5 percent, on average, driven by increases in licensed practical nurses (0.06 hours per resident day) and certified nursing assistants (0.13 hours per resident day). Facilities' annual labor expenses rose by about $273,000, but these costs were offset by higher net patient revenues (approximately $546,000), leaving net margins unchanged. Mandates did not increase the likelihood of facility closure. Overall, our findings indicate that minimum staffing mandates can meaningfully raise staffing levels without undermining the financial viability of nursing homes.

From Criticism to Comfort: The Relational Benefits of Long-Term Care Insurance

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ABSTRACT Objectives The objective of this study is to examine whether potentially eligible individuals with Partnership Long-Term Care Insurance (PLTCI) program experience stronger social networks and improved interpersonal relationships compared to those without coverage. Study Setting and Design Our analysis utilizes data from the Health and Retirement Study (HRS), a longitudinal survey of U.S. adults aged 50 and older, incorporating responses from the Leave-Behind Questionnaire administered biennially from 2004 to 2018. We merge these data with a dataset tracking state-level implementation of the PLTCI program, enabling us to construct a binary indicator of policy exposure based on respondents' state of residence. Using ordinary least squares (OLS) regression with two-way fixed effects, we estimate the effect of the PLTCI program on the relational outcomes of aging individuals. Data Sources and Analytic Sample The analytic sample includes HRS respondents potentially eligible for the PLTCI program at the time of its implementation, focusing on respondents and their spouse no more than 65 years without physical limitations per Activities of Daily Living (ADL) criteria. Depending on data availability, the sample size ranges from approximately 13,000 to 17,000 participants. Principal Findings The PLTCI program improved perceived relationships with children and spouses. Older adults reported less frequent criticism (4.3% decrease with children, p = 0.04, 95% CI: 0.3%–8.3%; 3.4% with spouse, p = 0.04), feeling let down (3.9% decrease with children, p = 0.01; 3.8% with spouse, p = 0.009), or being annoyed (3.5% decrease with children, p = 0.03). They also felt more comfortable opening up about worries (2.1% increase with children) and relying on close family members during serious problems (3.0% increase with children, p = 0.01). These effects were strongest among individuals aged 55 and older compared to younger individuals, non-Hispanic White respondents compared to non-Hispanic Black respondents, and those with higher household wealth compared to those with lower household wealth . Conclusions Beyond financial security, the PLTCI pro-

gram enhances older adults' social and emotional well-being by improving close relationships. These findings highlight the need to consider both economic and relational outcomes when evaluating long-term care policies.

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