

Veille scientifique en économie de la santé

Watch on Health Economics Literature

Février 2026 / February 2026

Assurance maladie	<i>Health Insurance</i>
Démographie	<i>Demography</i>
E-Santé – Technologies médicales	<i>E-health – Medical Technologies</i>
Économie de la santé	<i>Health Economics</i>
Environnement et santé	<i>Environmental Health</i>
État de santé	<i>Health Status</i>
Géographie de la santé	<i>Geography of Health</i>
Handicap	<i>Disability</i>
Hôpital	<i>Hospital</i>
Inégalités de santé	<i>Health Inequalities</i>
Pharmaceutiques	<i>Médicaments</i>
Méthodologie – Statistique	<i>Methodology - Statistics</i>
Politique de santé	<i>Health Policy</i>
Politique sociale	<i>Social Policy</i>
Politique publique	<i>Public Policy</i>
Prévention	<i>Prevention</i>
Psychiatrie	<i>Psychiatry</i>
Sociologie de la santé	<i>Sociology of Health</i>
Soins de santé primaires	<i>Primary Healthcare</i>
Systèmes de santé	<i>Health Systems</i>
Travail et santé	<i>Occupational Health</i>
Vieillesse	<i>Ageing</i>

Présentation

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

Certaines publications recensées sont disponibles gratuitement en ligne. D'autres, payantes, peuvent être consultées sur rendez-vous au [Centre de documentation de l'Irdes](#) ou être commandées auprès des éditeurs concernés. Des copies d'articles peuvent aussi être obtenues auprès des bibliothèques universitaires ([Sudoc](#)) ou de la [British Library](#). En revanche, aucune photocopie par courrier n'est délivrée par le Centre de documentation.

La collection des numéros de Veille scientifique en économie de la santé (anciennement intitulé Doc Veille) est consultable sur le site internet de l'Irdes : www.irdes.fr/documentation/veille-bibliographique-en-Economie-de-la-sante.html

Presentation

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

Some documents are available online for free. Paid documents can be consulted at the [IRDES Information centre](#) or be ordered from their respective publishers. Copies of journal articles can also be obtained from university libraries (see [Sudoc](#)) or the [British Library](#).

Please note that requests for photocopies or scans of documents will not be answered.

All past issues of Watch on Health Economics Literature (previously titled Doc Veille) are available online for consultation or download:

www.irdes.fr/english/documentation/watch-on-health-economics-literature.html



Reproduction sur d'autres sites interdite mais lien vers le document accepté : www.irdes.fr/documentation/veille-bibliographique-en-Economie-de-la-sante.html
Any reproduction is prohibited but direct links to the document are allowed: www.irdes.fr/english/documentation/watch-on-health-economics-literature.html

Veille scientifique en économie de la santé

Directeur de la publication

Denis Raynaud

Documentalistes

Véronique Suhard
Rouguiyatou Ndoye

Maquette & Mise en pages

Franck-S. Clérembault
Damien Le Torrec

Watch on Health Economics Literature

Publication Director

Information specialists

Design & Layout

ISSN : 2556-2827

Institut de recherche et documentation en économie de la santé
21-23 rue des Ardennes - 75019 Paris • Tél. : 01 53 93 43 56 • www.irdes.fr

Sommaire Contents

Assurance maladie

Health Insurance

- 13** Number Of States Providing Medicaid Hearing Aid Coverage For Adults Increased; Variability Was Substantive, 2017–23
Arnold, M. L., Tonti, L., Phillips, S., et al.
- 13** Medicare Advantage Enrollment Increased Disproportionately In Chain-Owned Dialysis Facilities After The Cures Act
Kim, D., Meyers, D. J., Nguyen, K. H., et al.
- 13** Using Policy Learning to Inform Health Insurance Targeting: A Case Study of Indonesia
Shah, V., Jones, A. M., Malenica, I., et al.

E-santé

E-Health

- 14** Does telemedicine technology affect prescribing quality in primary care? The case of antibiotics
Avdic, D., Kunz, J. S., Méndez, S. J., et al.
- 14** Optimal liability rules for combined human-AI health care decision
Chopard, B. et Musy, O.
- 14** Examining the social prescription process: Barriers, facilitators, and the role of health information technology
Haynes, D., Wedlow, M., Gilliam, K., et al.
- 15** The use of artificial intelligence in healthcare as perceived by the citizens and patients: a narrative review of the literature
Nuccetelli, F., Gabellone, V., Marsano, F., et al.
- 15** Factors influencing eHealth adoption among healthcare users in Türkiye: A Stepwise Logistic Regression Analysis
Ökem, Z. G., Özel, B. A., Günaydin, G. P., et al.
- 16** Making the Invisible Visible: Nurses' Stealth Work to Legitimize Their Telemedicine Coordination Role
Olive, M. V., Gastaldi, L. et Radaelli, G.

Economie de la santé

Health Economics

- 16** Scoping Review of Productivity-Adjusted Life Years (PALYs): Methods, Applications and Policy Implications
Ademi, Z., Abushanab, D., Arvez, M. J. A., et al.
- 16** Special issue in health economics
Barnay, T., Jusot, F. et Wittwer, J.
- 16** The effect of wealth and health status on joint saving and insurance decisions
Crainich, D.
- 17** Healthcare utilization and costs for cardiovascular diseases across different levels of bundled payment adoption in general practice: A data linkage study
Dros, J. T., Van Dijk, C. E., Verheij, R. A., et al.
- 17** The impact of periodic updates to health benefits plan: access gains without cost savings?
Espinosa, O., Rodriguez-Lesmes, P., Rodriguez, J., et al.
- 17** Value-Based Payment in Medicare: Progress, Challenges, and Future Directions
Figuerola, J. F., Duggan, C. E. et Joynt Maddox, K. E.
- 18** The Rise of Health Economics: Transforming the Landscape of Economic Research
Gschwent, L., Hammarfelt, B., Karlsson, M., et al.
- 18** Fee cuts for radiology and low-value imaging
Howard, D. H., Horny, M. et Dillender, M.
- 18** Maternity Care Bundled Payments In The Netherlands: Changes In Health Outcomes, Spending, And Care Delivery After 5 Years
Klootwijk, A., de Vries, E. F., Huang, X., et al.
- 19** The Impact of Alteplase Coverage on Health Equity for the Treatment of Ischemic Stroke in the USA: A Distributional Cost-Effectiveness Analysis
Majda, T., Mearns, E. S. et Kowal, S.

19 **Prioritisation, risk selection, and illness severity in a mixed healthcare system**

Olivella, P. et Vera-Hernández, M.

19 **Oral health care's contribution to catastrophic spending in Canada: a descriptive study**

Proaño, D., Allin, S., Essue, B. M., et al.

20 **Good intentions and the costs of inaction: Financial protection in Austria**

Stegner, C. et Cypionka, T.

Environnement et santé **Environmental Health**

20 **Gender at the crossroads of mental health and climate change: A scoping review**

Abu, T. Z. et Achore, M.

21 **Publish or Perish – do French hospitals disclose their greenhouse gas emissions for vertical differentiation?**

Clavel, N., Marraud, L., Lescher-Cluzel, M., et al.

21 **The 2025 report of the Lancet Countdown on health and climate change**

Romanello, M., Walawender, M., Hsu, S. C., et al.

21 **Une seule santé et gouvernance des données : le rôle de l'Agence nationale de sécurité sanitaire de l'alimentation, de l'environnement et du travail**

Vallet, B. et Breton, P.

État de santé **Health Status**

22 **Impact of specialist palliative care on utilization of healthcare and social services at the end-of-life: a nationwide register-based cohort study**

Ahtiluoto, S. E., Carpen, T. P., Forsius, P. T., et al.

22 **Diagnostic delay in rare diseases in the Campania region: addressing ageing, gender disparities, and the “postcode lottery effect” to reduce the patient odyssey**

Cirillo, C., Duraccio, R., Fordellone, M., et al.

23 **Assessing the impact of chronic respiratory diseases on COVID-19 in-hospital mortality in the Italian population: a comparative study**

Fattori, S., Jona Lasinio, G., Alfò, M., et al.

23 **Basing healthcare decisions on value: patient-reported outcomes for patients diagnosed with breast cancer in a European cohort**

Gorostiza, A., Cacicedo, J., Alayo, I., et al.

23 **Rates and determinants of alcohol-drinking categories in France: a general population survey**

Rolland, B., de Ternay, J., Haesebaert, J., et al.

24 **Interaction effects on health between perceived neighbourhood social cohesion and demographic changes: a longitudinal study**

Sauzet, O. et Schäfer, M.

24 **Long-term trends in mortality by living arrangements and the role of socioeconomic factors, Finland 1991–2020**

Suulamo, U. K., Remes, H. M., Tarkiainen, L. H., et al.

Géographie de la santé **Geography of Health**

25 **Medical training pathways and underdoctored areas: a qualitative study of doctors working in areas that struggle to recruit and retain**

Brewster, L., Chekar, C. K., Lambert, M., et al.

25 **Vieillesse de la population, équipements, services et mobilités. Radiographie de trois départements de faible densité du sud de la France**

Maléfant, L.

25 **Urban neighborhood factors influencing adolescent health and well-being: A qualitative study among adolescent boys in the city of Utrecht, the Netherlands**

Roelandt, J., Czymoniewicz-Klippel, M. T., Simons, M., et al.

Handicap **Disability**

26 **How does disability affect incomes? An empirical study on older European workers**

Bondoux, J., Barnay, T., Jusot, F., et al.

- 26** The role of financial difficulty on the health and well-being of adults with functional limitations that may require long-term services and supports

Chen, L. et Kietzman, K.

Hôpital Hospital

- 27** Hospital Patient Experience Worsened With the COVID-19 Pandemic, Especially for Older Adults, and Remains Worse than Before
Beckett, M. K., Cohea, C. W., Saliba, D., et al.
- 27** Triage et urgences pédiatriques. Expérience de l'hôpital Necker-Enfants-Malades
Chéron, G.
- 27** Adjusting hospital reimbursements to the onset of a new disease: Lesson from Covid-19
Copello, F., Dattaro, M., Leporatti, L., et al.
- 28** La tarification à l'activité (T2A/GHM) entre paiement et régulation : tarifs, secteur et implications pour la santé publique
Milcent, C.
- 28** The impact of pre-admission care on hospital mortality: results of an instrumental variable analysis from Italy
Moscone, F., Tosetti, E. et Vittadini, G.
- 29** Hospital Finances, Operations, And Patient Experience Remain Stable After Oregon's Hospital Payment Cap Was Implemented
Murray, R. C., Ryan, A. M. et Whaley, C. M.
- 29** Impact of midwifery-led units in Spain: lessons from the first 5 years
Palau-Costafreda, R., Orus-Covisa, L., Vicente-Castellví, E., et al.
- 29** Seeking evidence of intersectional effects in emergency hospital readmissions of adults in England, 2016 - 2019
Spencer, J., Ward, R., Bortnowschi, M., et al.
- 30** Unmasking and Rethinking Hierarchical Inefficiency in Healthcare Systems
Unaia, T. J., Andrews, A. et Kimpton, S.

Inégalités de santé Health Inequalities

- 30** Migrants' and immigrants' understandings of health and disease. Medical diversity in two diverse urban neighbourhoods
Becker, K., Kraas, F. et Butsch, C.
- 31** Geographical and socio-economic inequalities in years of life lost across Norwegian municipalities and city districts in 2019: an ecological registry-based study
Breivik, H., Forthun, I., Knudsen, A. K. S., et al.
- 31** The prevalence of multimorbidity with mental and physical health for people who experience homelessness: a systematic review
Chilman, N., Schofield, P., Laporte, D., et al.
- 31** Social Inequality in Health as a political topic in Denmark in the 21st century
De Montgomery, C. J. et Vrangbæk, K.
- 32** Health mediation mechanisms influencing healthcare utilization of underserved populations: a qualitative study in 2 districts in France
Elodie, R., Leila, R., Judith, M. F., et al.
- 32** Cash Transfers and Health Outcomes: Evidence from Italian Municipalities
Fontana, S., Guccio, C., Pignataro, G., et al.
- 32** Mothers' level of education and infant health. Causal effects of the introduction of a school reform in Norway
Grytten, J. et Skau, I.
- 33** Social deprivation as a key driver of spatial disparities in end-stage kidney disease incidence
Hamroun, A., Niang, A. T., Occelli, F., et al.
- 33** To what extent does the onset of limiting health condition co-occur with poverty entries across European countries and educational groups?
Hiilamo, A.
- 34** The price of mobility: How migration shapes health outcomes in China
Huang, Q., Zhou, J., Xu, Z., et al.
- 34** Income inequality modified adolescent substance use trajectories from 2018-19 to 2020-21: Findings from the COMPASS study
Hunter, S., Rai, U., Crandall-Nicolet, A. B., et al.

- 34** "Take away the greed of the private landlord housing market ... because that is killing people": Examining the political economy of housing and health inequalities in four English coastal towns
McGowan, V. J.

- 35** A scoping review of multiple deprivation indices in Europe
Mogin, G., Gorasso, V., Idavain, J., et al.

- 35** Testing the Healthy Immigrant Effect on Youth Alcohol Use: A Longitudinal Study
Muyingo, L., Mackinnon, S., Sherry, S. B., et al.

- 36** Migration trajectories, uncertainty and health: a conceptual review
Rast, E., Detering, B., Rohleder, S., et al.

- 36** Association Between Socioeconomic Disadvantage and Low-Value Care in Acute Care Hospitals in Japan: Cross-sectional Study
Sato, S., Yasunaga, H., Matsuo, Y., et al.

- 36** Devolution, Health and Health Inequalities in Greater Manchester
Sweeney, N. P.

- 37** An index of multiple deprivation in Sweden: measuring area-level socioeconomic inequalities
Van Der Velde, L., Shabaan, A. N., Mattsson, M., et al.

- 37** Prévalence des troubles psychiques et déterminants du parcours de soins chez le public migrant précaire : données d'une revue de la littérature
Vieira, L. et Pontonnier, A. L.

- 38** The association of sex and socioeconomic status with multimorbidity: results from the UK Biobank
Youssef, D. M., Harris, K., Grobbee, D. E., et al.

- 38** Unequal high streets? A spatial analysis of inequalities in health-related amenities in England from 2014-2024
Zied Abozied, E., Munford, L., Todd, A., et al.

Politique de santé Health Policy

- 39** Divergences et convergences idéologiques sur les dépenses sociales et de santé
Jacques, O., Ben Jelili, E. et Arpin, E.

- 39** LGBTQ+ Health, Policy, and Politics: Advances, Challenges, and Potential Opportunities
Nguyen, K. H., Menard, L., Allen, H., et al.

- 39** Same as It Ever Was? Persistence and Transformation in US Health Care Policy.
Oberlander, J.

- 40** Health workforce resilience in the age of polycrisis: a framework to support health workforce policy and planning
Onvlee, O., Jacobs, E., Tromp, N., et al.

- 40** L'efficacité des interventions de santé publique en France : un retour en arrière ?
Ridde, V., Alla, F., Cambon, L., et al.

- 40** A scoping literature review of rehabilitation policy recommendations during the COVID-19 pandemic in the WHO European Region
Thomas, C., Gosling, J., Ashton, R. E., et al.

- 41** Places of end-of-life care and death in health policies of four countries (EOLinPLACE Project)
Van de Beek, S. H., Gomes, B., Eckels, K., et al.

- 41** An Inventory of Policy Levers to Reduce Low Value Care: Results of a Rapid Scoping Review
Warkentin, L. M., Tjosvold, L. et Bond, K.

Prévention Prevention

- 42** Advancing Equity in Preventive Care: Leveraging Hospital Admissions for Vulnerable Populations
Allaudeen, N., Huberman, D. B. et Le, E.

- 42** Democracy, Trust, and Political Orientation: Disentangling Mechanisms Shaping Individuals' Vaccine Attitudes
Antonini, M., Singh, R., Melegaro, A., et al.

- 43** Éducation Thérapeutique du Patient dans les maladies rares : bilan des appels à projets DGOS 2019-2020 et perspectives d'amélioration
Bouille, R., Balbolia, S., Barbet, A., et al.

- 43** Vaccination and Risk Aversion: Evidence From a Flu Vaccination Campaign
Garrouste, C., Juet, A. et Samson, A. L.

- 43 Funding Health Promotion Activities to Reduce Avoidable Hospital Admissions in Frail Older Adults (HomeHealth): Further Challenges to the "Cost-Effective but Unaffordable" Paradox**
Hunter, R. M., Frost, R. et Kalwarowsky, S.
- 43 General population preferences for health-related protective behaviors during infectious disease emergencies: a systematic review of conjoint-analysis studies**
Li, N., Rambod, B., Dukers-Muijers, N., et al.
- 44 Cost-Effectiveness of a Universal School-Based Mental Health Prevention Program: An Economic Modeling Study in a Limited Income Context**
Nguyen, H. T., Nguyen, A. Q., Nguyen, N. T., et al.
- 44 Améliorer la connaissance et la reconnaissance des interventions non médicamenteuses : implications pour la santé publique d'une étude participative et de consensus**
Ninot, G., Descamps, E., Achalid, G., et al.
- 46 Mapping Mental Health Across US States: the Role of Economic and Social Support Policies**
Donnelly, R. et Farina, M. P.
- 46 Optimal mental health belief formation with information avoidance: A decision-theoretic model**
Kim, D.
- 47 Integrating Mental Health and Substance Use Treatment With Emergency and Primary Care: the Case of Opioid Use Disorder and Suicide**
Krawczyk, N. et Samples, H.
- 47 COVID-19, economic downturn, and long-term trajectories of population mental health: evidence from two nationally representative British birth cohorts at the intersection of gender and socioeconomic position**
Moreno-Agostino, D., Ploubidis, G. B. et Das-Munshi, J.
- 47 L'intelligence artificielle en psychiatrie : promesses cliniques, reconfiguration ontologique et émergence d'un nouveau cadre épistémique**
Mouchabac, S. et Mallard, S.
- 48 Review of Emergent Financing Models for Mental Health Crisis Systems**
Purtle, J., Mauri, A. I. et Frederick, D.
- 48 Integrative models of psychopathology and psychotherapy: A PRISMA-based scoping review**
Saur, R., Fourel, E., Dos Santos, S., et al.
- 48 Virginia's inpatient mental healthcare geography post SB260**
Schwoerer, M. et Leslie, T. F.
- 48 Intelligence artificielle et psychiatrie : inquiétude et quels enjeux ?**
Shadili, G. et Favré, P.
- 49 Adverse childhood experiences partially mediate sexual minority disparities in depression, anxiety, and suicidality in a population-based study**
Smart, B. D., Pachankis, J. E. et Bränström, R.
- 49 The same, but different: Understanding responsibility attributions for depression with a cross-national survey in the United States and Germany**
Wagner, A., Reifegerste, D. et Scherr, S.

Psychiatrie

Psychiatry

- 45 Incentivizing co-occurring disorder diagnoses through blended payments**
Baslock, D., Manuel, J. I. et Stanhope, V.
- 45 The impact of PhD studies on mental health—a longitudinal population study**
Bergvall, S., Fernström, C., Ranehill, E., et al.
- 45 Le vécu de l'électroconvulsivothérapie par les professionnels de santé**
Bouaziz, L. et Adrien, V.
- 46 2025 ESC Clinical Consensus Statement on mental health and cardiovascular disease: developed under the auspices of the ESC Clinical Practice Guidelines Committee: Developed by the task force on mental health and cardiovascular disease of the European Society of Cardiology (ESC) Endorsed by the European Federation of Psychologists' Associations AISBL (EFPA), the European Psychiatric Association (EPA), and the International Society of Behavioral Medicine (ISBM)**
Bueno, H., Deaton, C., Farrero, M., et al

50 Estimating Medicaid Reimbursement For Psychological Services

Zhu, J. M., Huntington, A., Mitchell, E., et al.

50 Reported Strategies by Medicaid Managed Care Organizations to Improve Access to Behavioral Health Services

Zhu, J. M., Rowland, R., Suneson, I., et al.

Sociologie de la santé *Sociology of Health*

51 Le service de santé universitaire au prisme du genre : une étude de la portée

Azadi, B. et Kivits, J.

51 Être ou ne plus être les « petites mains » du chirurgien. L'impossible construction identitaire des infirmières de bloc opératoire

El Haïk-Wagner, N.

51 How do community assets support health in a rural community? An ethnographic case study

Hayes, J., Edwards-Smith, L., Byng, R., et al.

51 Favoriser l'engagement des bénéficiaires dans un programme sport-santé accessible sur prescription médicale : perspectives phénoménologiques et microsociologiques

Lefèvre, L., Orival, T., Knobé, S., et al.

52 A decade of discourse: Exploring sentiments and trends around immigration on social media from 2014 to 2024

Nguyen, T. T., Mullaputi, P. S. P., Yue, X., et al.

52 La déstandardisation des parcours de psychiatres salariés. Logiques d'adaptation dans une organisation sous contraintes

Robicquet, P.

53 Une crise sanitaire révélatrice d'une crise plus profonde au sein de la profession. Le cas des sages-femmes hospitalières en Île-de-France pendant la pandémie de Covid-19

Schantz, C., Rodino, I., Yahiatene, L., et al.

53 Beyond Preferences: Rethinking Shared Decision-Making Through the Lens of Care

Turrini, M., Valenti, R., Ladegaard Knox, J. B., et al.

Soins de santé primaire *Primary Healthcare*

54 A composite and synthetic index of potentially avoidable hospitalization in adults to assess primary care quality: an application across Italian geopolitical areas

Alizadeh, A. H., Cuomo, M., Burgio, A., et al.

54 Integrating Primary Care and Public Health: Promising Pathways to Building Infrastructure and Delivering Services

Anderson, K. M., Borrell, L. N. et Thorpe, L.

54 Impact of quality clusters on antibiotic prescribing patterns. A difference-in-differences study from Danish general practice

Bjørnskov Pedersen, L., Bundgaard, M., Klausen Fredslund, E., et al.

55 Patients as Boundary Subjects in Home Care: How Patients Coordinate (Inter-) Professional Work

Diel, M., Weber, C. E., Müller, C., et al.

55 Judicious resource managers or administrative intermediaries: A systematic review of family physician perspectives on the administrative process of referring patients to other clinicians in high income countries

Elma, A., Scholes, A. K., Singer, A., et al.

56 How to increase the supply of primary care services in underserved areas? The impact of the location of multidisciplinary primary care teams on the density of physiotherapists in France

Galharret, Y., Videau, Y. et Mousquès, J.

56 Sortir de la médecine générale libérale : les effets croisés de la socialisation professionnelle, de classe et de genre

Garcia, S., Gelly, M. et Hamelin, C.

56 How to scale up and implement integrated care?

Ginneken, D. E. V., Struckmann, D. V., Rijken, D. M., et al.

56 Nurse-led models of care and their potential to improve primary healthcare for refugees in Germany: A qualitative multiple-case study

Gold, A. W., Perplies, C. et Bozorgmehr, K.

57 New ways of working in Irish general practice: Policy implications for medical workforce planning.

Humphries, N., Hanlon, H. R., O'Callaghan, M., et al.

- 57 The impact of vertical integration on health care delivery and costs: Evidence from physician–pharmacy integration**
Kakani, P.
- 57 Nursing shortages and patient outcomes**
Kelly, E., Propper, C. et Zaranko, B.
- 58 A theory-based randomised controlled trial to increase delivery of behaviour change interventions by healthcare professionals**
Keyworth, C., Armitage, C. J., Johnson, J., et al.
- 58 Health reform implementation during poly-crises: a qualitative study on health workforce perspectives in Finland**
Kihlström, L., Viita-aho, M., Keskimäki, I., et al.
- 59 The impact of primary care networks on emergency hospitalisations in the English NHS: an interrupted time series analysis**
Kovacevic, L., Forbes, L., Ashrafian, H., et al.
- 59 Community health workers: a comparative assessment of capacities of a global policy approach in selected European health systems**
Kuhlmann, E., Lotta, G., Burau, V., et al.
- 59 State Policy Strategies to Promote the Recruitment and Retention of the Behavioral Health Workforce**
Last, B. S. et Zhu, J. M.
- 60 Impact of COVID-19 on primary care consultation mode in England: An interrupted time series analysis**
Mesiano, N. et Santos, R.
- 60 From recruitment to retention of young doctors: a comparative analysis of policies in Poland and the United Kingdom**
Michalska, K., Aquines, A. G., McVey, L., et al.
- 60 Adapting Healthcare Workforce Distribution Amid Multiple Crises: A 12-Year Analysis of Physician Allocation Patterns in Turkey (2013-2024)**
Öntaş, E. et Yavuz, C. I.
- 61 Provision of community health services and use of hospital care in England: Nationwide retrospective observational study.**
Parkinson, B., Sutton, M. et Meacock, R.
- 61 Impact of quality clusters on antibiotic prescribing patterns. A difference-in-differences study from Danish general practice**
Pedersen, L. B., Bundgaard, M., Fredslund, E. K., et al.
- 62 Interventions aiming to change multiple healthcare professional behaviors: A systematic review**
Silva, C. C., Marques, M. M., Van Allen, Z., et al.
- 62 Périmètre d’attractivité territoriale de la maîtrise de stage : étude de cohorte rétrospective**
Taha, A., Thébault, J. L., Renard, V., et al.

Systèmes de santé Health Systems

- 63 Economic evaluation of participation in Community Led Organisations for individuals living in disadvantaged areas in the UK**
Mason, H., Irvine, N., Manoukian, S., et al.
- 63 The Affordable Care Act: At the Nexus of Politics and Policy**
Morize, N.
- 63 Backlogs, waiting times and waiting lists of elective surgeries across OECD countries**
Siciliani, L., Lafortune, G., Canaud, M. C., et al.
- 64 Lots of Pain for Little Gain: Three Decades of Medicaid Estate Recovery**
Spishak-Thomas, A., Sandoe, E. et Howard, H.
- 64 Les réformes des systèmes de santé en Europe**
Les Tribunes de la santé
- 64 The influence of public health organization on response to the COVID-19 pandemic in four Canadian provinces: A comparative qualitative analysis**
Usher, S., Allin, S., Gautier, L., et al.

Travail et Santé Occupational Health

- 65 The effects of commuting and working from home arrangements on mental health**
Botha, F., Kabátek, J., Meekes, J., et al.

- 65 The Effects of Paid-Sick-Leave Mandates on Care Provision**
Guo, X. et Peng, L.
- 65 Sickness absence with common mental disorders and antidepressant prescriptions across different employment branches during as compared to before the Covid-19 pandemic—an observational study covering the Swedish population aged 18–65 years**
Kirchner, S., Gémes, K., Josefsson, P., et al.
- 66 Fréquences d'exposition aux principaux facteurs de risque biomécaniques d'usure professionnelle chez les femmes et les hommes dans la cohorte CONSTANCES**
Morvan, G., Bodin, J., Major, M. E., et al.
- 66 Multimorbidity and the indirect cost of productivity loss from health-related work absenteeism in Belgium**
Tran, P. B., Berete, F., De Clercq, B., et al.
- 67 Global, Regional, and National Burden of DALYs Attributable to Occupational Risks, 1990–2021: Trends and Projections to 2030**
Zong, X., Hu, H., Li, H., et al.
- 69 Evaluating the Effectiveness of an Integral Neighbourhood-oriented Approach for Healthy Ageing: Findings from a Cluster-randomised Controlled Trial in Socioeconomically Diverse Communities**
Duijsens, L. J. E., Bolman, C. A. W., Peels, D. A., et al.
- 70 Perspectives of healthcare professionals on medical care in nursing homes in Germany and The Netherlands: an explorative study using qualitative content analysis**
Fassmer, A. M., Grenz, A., Ennen, M., et al.
- 70 Different systems, same challenges: a comparative analysis of long-term care resilience in Norway, Finland, the Netherlands, Romania, Spain, Italy and Australia**
Felder, M., Bal, R., Ree, E., et al.
- 71 Immigrant Staff in Nursing Homes: Mitigating Staffing Shortages During the COVID-19 Pandemic**
Jun, H., Geng, F., McGarry, B. E., et al.
- 71 Un siècle de vieillissement en France, 1921–2021. Disparités de genre et de classe**
Kesztenbaum, L.
- 71 Is Caring Productive? The Effect of Adult Social Care on Paid Production in England**
Longo, F., Claxton, K., Mason, A., et al.
- 71 Mortality risk factors in Catalonia's long-term care system: A population-based survival analysis**
Prades-Colomé, A.
- 72 Is home always the best place to live? Preferences for place of residence and long-term care among the community-dwelling oldest old in Finland**
Pulkki, J. M., Aaltonen, M. S., Jylhä, M. K., et al.
- 72 Cognitive ageing: sex and life course social class differences in England**
Richards, L., Maharani, A. et Präg, P.
- 72 Long-Term Care at Advanced Ages: The Effect of Spousal Bereavement on Institutional Care Needs**
Schouwenaar, C., Koning, P., Krabbe-Alkemade, Y., et al.
- 73 Influence of prior knowledge and experience on willingness to pay for home hospice services: a contingent valuation study**
Steigenberger, C., Leiter, A. M., Siebert, U., et al.

Vieillesse Ageing

- 67 Strategies to improve recruitment, retention, working conditions, and skills among the long-term care workforce: An umbrella review of existing evidence**
Badache, A. C., Dobrosavljevic, M. et Barber, S. L.
- 68 Vieillir avec une maladie neurodégénérative Redéfinitions de la valeur sociale au prisme du genre et de l'âge**
Béliard, A. et Blum, P.
- 68 Inégales vieillesse**
Benquet, M., Lemarchant, C. et Rossigneux-Méheust, M.
- 68 Décès du conjoint et mobilité résidentielle en France : Des désavantages cumulatifs aux âges avancés**
Chabot, T. et Le Roux, G.
- 69 Targeting "average Jane": The co-modification of for-profit nursing home care in the Netherlands**
De Brabandere, L., Schuurmans, J., Van der Woerd, O., et al.

73 Unequal care, unequal health care? Gender differences in health care use after adult care access

Wang, W. et Costa-Font, J.

73 The Evolution of Long-Term Care and Health Policy in the United States

Werner, R. M., Hoffman, A. K. et Konetzka, R. T.

Health Insurance**► Number Of States Providing Medicaid Hearing Aid Coverage For Adults Increased; Variability Was Substantive, 2017–23**

ARNOLD, M. L., TONTI, L., PHILLIPS, S., *et al.*
2025

Health Affairs 44(12): 1522-1529.

<https://doi.org/10.1377/hlthaff.2025.00270>

This study examined state-level Medicaid hearing aid coverage for adults ages twenty-one and older across the United States. Using policy surveillance principles, we compiled a cross-sectional data set detailing hearing aid coverage policies from fifty states and Washington, D.C., as of December 31, 2023. We then merged these data with individual-level American Community Survey data to estimate national rates of Medicaid hearing aid coverage and identify how coverage varies according to demographic characteristics. We identified thirty-two states with Medicaid hearing aid coverage for adults, with substantial variability in policy features of that coverage. Approximately 70 percent of Medicaid beneficiaries ages twenty-one and older lived in a state with coverage. Women, working-age adults, and Black adults had slightly lower odds of coverage, whereas Hispanic and Latino and other or multiple race beneficiaries had higher odds of coverage. Expanding and standardizing Medicaid coverage of hearing aid benefits in line with best practices could improve access and utilization.

► Medicare Advantage Enrollment Increased Disproportionately In Chain-Owned Dialysis Facilities After The Cures Act

KIM, D., MEYERS, D. J., NGUYEN, K. H., *et al.*
2025

Health Affairs 44(12): 1514-1521.

<https://doi.org/10.1377/hlthaff.2025.00361>

The 21st Century Cures Act, which took effect in January 2021, allowed Medicare beneficiaries with end-stage renal disease to enroll in Medicare Advantage (MA) plans. The dialysis industry is highly concentrated, with two large chains providing 75 percent of Medicare dialysis treatments. Their market dominance

allows them to negotiate substantially higher dialysis reimbursements from MA plans than from traditional Medicare, making MA enrollment financially beneficial to them. Applying a difference-in-differences approach to Medicare enrollment and claims data from the period 2017–22, we found that MA enrollment increased by a 5.7-percentage-point higher rate among patients treated in chain-owned facilities relative to those treated in independent facilities after the Cures Act, for an increase of 130 percent of the pre-Cures Act mean within chain facilities. The differential MA growth in chain facilities was larger for racial and ethnic minority, dual-eligible, and rural patients. These findings suggest that the Cures Act may increase the financial strength of chain facilities, with disproportionate increases in MA enrollment among low-income and racial and ethnic minority populations with kidney failure who are treated in these facilities.

► Using Policy Learning to Inform Health Insurance Targeting: A Case Study of Indonesia

SHAH, V., JONES, A. M., MALENICA, I., *et al.*
2025

Health Economics 34(12): 2270-2296.

<https://doi.org/10.1002/hec.70031>

ABSTRACT This paper demonstrates how optimal policy learning can inform the targeted allocation of Indonesia's two subsidized health insurance programmes. Using national survey data, we develop policy rules aimed at minimizing "catastrophic health expenditure" among enrollees of APBD or APBN, the two government-funded schemes. Employing a super learner ensemble approach, we use regression and machine learning methods of varying complexity to estimate conditional average treatment effects and construct policy rules to optimize program benefits, both with and without budget constraints. We find that the financial impact of APBD enrollment over APBN differs with household characteristics, particularly demographic composition, socioeconomic status, and geography. Households assigned to APBD under the policy rule are typically urban-based with better facilities, whereas rural households with less accessible healthcare are assigned to APBN—a pattern intensi-

fied under budget constraints. Both constrained and unconstrained optimal policy assignments show lower expected catastrophic expenditure risk than the current assignment strategy. This study contributes to the literature on heterogeneous treatment effects, opti-

mal policy leaning, and health financing in developing countries, showcasing data-driven solutions for more equitable resource allocation in public health insurance contexts.

E-Health

► **Does telemedicine technology affect prescribing quality in primary care? The case of antibiotics**

AVDIC, D., KUNZ, J. S., MÉNDEZ, S. J., *et al.*
2026

Journal of Health Economics 105: 103096.
<https://doi.org/10.1016/j.jhealeco.2025.103096>

We study the impact of telemedicine technology on antibiotic prescription rates using linked administrative data from Australia on physicians and their patients. We classify physicians by their relative use of virtual consultations after the introduction of government-subsidised telemedicine services and compare their antibiotic prescribing rates before and after telemedicine services became available. We find that more intense telemedicine adopters prescribe less antibiotics while keeping prescribing quality unchanged. Our results are not explained by patient sorting, doctor shopping, or changes in the intensity of consultations.

► **Optimal liability rules for combined human-AI health care decision**

CHOPARD, B. ET MUSY, O.
2025

Annals of Economics and Statistics(158): 81-104.
<https://doi.org/10.2307/48845129>

The integration of AI for healthcare redefines medical liability, transforming decision-making into a collaborative process between technology and its user. When a harm is caused, both AI users and manufacturers may be responsible. The judicial system has yet to address claims of this nature. We develop a model with bilateral care to analyze which liability rules lead to socially efficient investment in care by AI producers and users. Both parties may be subject to strict liability,

negligence rules, or hybrid regimes-where one agent operates under strict liability while the other is subject to fault-based liability. For each regime, we examine the role of the compensation-sharing scheme between users and producers. The European Parliament's latest AI Liability Directive for the medical field supports a strict liability regime for AI producers and a fault-based liability regime for AI users. Our findings confirm that this framework achieves social efficiency in healthcare. While a new regulatory framework is not strictly necessary, we also identify an alternative socially efficient regime in which the physician alone assumes full medical liability.

► **Examining the social prescription process: Barriers, facilitators, and the role of health information technology**

HAYNES, D., WEDLOW, M., GILLIAM, K., *et al.*
2025

Social Science & Medicine 387: 118668.
<https://doi.org/10.1016/j.socscimed.2025.118668>

Social, economic, and environmental conditions are known to impact up to 50 % of an individual's health. The process of identifying needs and referring individuals to resources is social prescribing. While technologies have been developed, a major barrier is that the social prescription process is poorly understood. Few healthcare systems have tools or workflows that systematically collect individual needs and provide reliable referrals to Community-Based Organizations (CBOs). The purpose of this research is to understand the existing process of a healthcare system and implement a digital health tool to assess its alignment with the healthcare system. We conducted 21 semi-structured interviews with clinical teams (i.e., doctors, nurses, social workers, and administrators)

to understand the barriers and facilitators for Health Information Technology (HIT) and social care referrals. We also piloted a HIT, Smart Community Health, with 21 recruited participants from the healthcare system. Our results show that barriers exist at the individual level, healthcare system level, and across CBOs. Healthcare team members used interpersonal communication, championing, and person-centered care to facilitate social care referrals to CBOs. Lastly, the role of HIT remains ambiguous; participants stated that there would be both positive and negative aspects of integrating technology within this process. When we piloted the HIT with 21 participants, we found that 61 % of patients were able to connect with CBOs, but only 26 % were able to get resources. This indicates that there are still significant challenges to getting resources to individuals with needs.

► **The use of artificial intelligence in healthcare as perceived by the citizens and patients: a narrative review of the literature**

NUCCETELLI, F., GABELLONE, V., MARSANO, F., *et al.*
2025

European Journal of Public Health 35(6): 1092-1099.
<https://doi.org/10.1093/eurpub/ckaf189>

The growth of scientific literature on large language models (LLMs), such as ChatGPT, anticipates their central role for accessing health information but poses potential risks, including the false belief that artificial intelligence (AI) could replace doctors in providing reliable information. Our study, part of the Slow AI project launched in partnership with the Slow Medicine ETS Association, reviewed the literature on ChatGPT use by the public, analyzing citizens' and patients' perceptions of using AI for health-related questions, identifying key benefits and concerns, and providing recommendations for the safe and effective use of LLMs. We conducted a narrative review following PRISMA guidelines, including qualitative, quantitative, and mixed-methods studies, selected through a search of the PubMed database. Data were extracted and analyzed using a predefined form. Out of 388 records, 120 studies were included, primarily from the USA (65), Europe (19), and Asia (15). Most studies focused on general medicine (37), with patients (57) being the main participants. Key findings include that LLMs improve access to health information, aiding diagnostic accuracy and patient understanding. However, risks exist, such as inaccurate or outdated information, lack of empathy, and privacy

concerns. These challenges highlight the need for reliable AI training with real-world data and clinician oversight to mitigate risks. Lastly, while LLMs can improve communication, they should complement, not replace human interaction. LLMs in healthcare offer great potential but also present risks. Safeguards and clinician oversight are crucial to preserve patient safety and doctor-patient relationship.

► **Factors influencing eHealth adoption among healthcare users in Türkiye: A Stepwise Logistic Regression Analysis**

ÖKEM, Z. G., ÖZEL, B. A., GÜNAYDIN, G. P., *et al.*
2026

Health Policy 165: 105539.

<https://doi.org/10.1016/j.healthpol.2025.105539>

Background eHealth services can improve healthcare access in Türkiye, yet disparities remain across socio-demographic groups. Despite major investments, quantitative evidence on user experiences with national eHealth platforms is limited. Objective To identify factors influencing eHealth use, focusing on three nationally available applications: Central Physician Appointment System (CPAS), Personal Medical Record System (PMR) and a self-diagnostic/referral system (e-diagnosis). Methods A cross-sectional survey of 450 participants collected data on socio-demographics, health status, internet access, and eHealth use. Stepwise logistic regression and mediation analysis were applied. Results Higher educational attainment was consistently associated with greater eHealth use (university vs. primary, odds ratio [OR]=1.76, 95% confidence interval [CI]:0.54–2.98, $p<0.001$); gender, household size, income, and residence were not significant. Age-related differences were mediated by internet access and user engagement, including perceived ease of use (OR=3.12, 95% CI:2.25–3.98, $p<0.001$), prior evaluations of doctors/hospitals (OR=2.51, 95% CI: 0.38–4.64, $p<0.01$), and unsuccessful CPAS attempts (OR=0.36, 95% CI:0.14–0.91, $p<0.01$). Chronic disease status had no effect after adjusting for internet access and eHealth engagement. Higher education was linked to greater use of CPAS and PMR, and these platforms partly explained the overall association between education and eHealth use (indirect effects $p\leq 0.01$). Conclusion Educational attainment emerged as the strongest predictor of eHealth adoption, partly mediated through CPAS and PMR use. Engagement and usability factors outweighed age and structural characteristics. These highlight the importance of

user-centered design, digital literacy support, and targeted interventions to reduce disparities and may inform strategies in countries seeking to optimize eHealth initiatives.

► **Making the Invisible Visible: Nurses' Stealth Work to Legitimize Their Telemedicine Coordination Role**

OLIVE, M. V., GASTALDI, L. ET RADAELLI, G.
2026

Social Science & Medicine 388: 118746.

<https://doi.org/10.1016/j.socscimed.2025.118746>

When new digital technologies are implemented, nurses are usually delegated several new organizing tasks and responsibilities. This accumulation of tasks does not always translate into improved roles for nurses, especially when their organizing work remains invisible to, and underestimated by, physicians. We explore what nurses might do to legitimize their organizing work to physicians. Empirically, we performed a longitudinal case study of a new telemedicine system in Italy, where nurses appropriated coordination respon-

sibilities. We discovered how nurses enacted 'stealth work' to successfully upgrade their role. Their stealth work included: (i) appropriating organizing tasks when these were understood as scut work by physicians, thus avoiding jurisdictional conflicts; (ii) gatekeeping the organizing domain to develop unique expertise that others could not replicate or replace; and (iii) upgrading 'scut work' into 'heart-sink' work to claim epistemic legitimacy. Our findings contribute to the 'ecological' debate in the sociology of professions, explaining how lower-status professionals can legitimize their 'invisible work' and improve their role in care processes. Stealth work is an affordable relational work for nurses: they can exploit the initial invisibility to appropriate new tasks, gatekeep the jurisdiction, develop unique expert knowledge, and use this as an effective resource for negotiation with higher-status professionals. Our findings also contribute to the 'epistemic injustice' debate in the literature, explaining how nurses can transform physicians' perception of organizing work from 'scut work' (requiring nonexpert knowledge) to 'heart-sink work' (i.e., requiring expert knowledge that physicians are 'too late' or 'too busy' to develop).

Economie de la santé

Health Economics

► **Scoping Review of Productivity-Adjusted Life Years (PALYs): Methods, Applications and Policy Implications**

ADEMI, Z., ABUSHANAB, D., ARVEZ, M. J. A., *et al.*
2025

PharmacoEconomics 43(12): 1367-1388.

<https://doi.org/10.1007/s40273-025-01544-6>

To understand the application of productivity-adjusted life years (PALYs) as an outcome measure across various disease contexts.

► **Special issue in health economics**

BARNAY, T., JUSOT, F. ET WITTEWER, J.
2025

Annals of Economics and Statistics(158): 1-6.

► **The effect of wealth and health status on joint saving and insurance decisions**

CRAINICH, D.
2025

Annals of Economics and Statistics(158): 105-124.

<https://doi.org/10.2307/48845130>

The paper analyzes the propensity to seek protection against health risks through insurance contracts and savings. We propose a theoretical model that characterizes the joint demand for these two risk management instruments when individuals are exposed to a disease that has financial and health consequences. We then establish the conditions under which reduced wealth and deteriorated health have a negative effect on this joint demand. Regarding the specific effect of health status on the propensity to take out insurance and save, recent experimental studies indicate that these conditions are likely to be met in practice, rais-

ing the question of financial protection for the most vulnerable individuals.

► **Healthcare utilization and costs for cardiovascular diseases across different levels of bundled payment adoption in general practice: A data linkage study**

DROS, J. T., VAN DIJK, C. E., VERHEIJ, R. A., *et al.*
2026

Health Policy 163: 105476.

<https://doi.org/10.1016/j.healthpol.2025.105476>

Background Bundled payments for patients with cardiovascular diseases (CVD) aim to enhance primary care utilization in the Netherlands. **Objective** This study assesses changes in healthcare utilization patterns and costs for CVD between 2014 and 2019, while investigating the potential association with bundled payment adoption. **Method** We studied patients at very high risk for CVD with routinely recorded nationwide healthcare data, using an observational study design. Multilevel logistic- and gamma regressions were conducted to assess healthcare utilizations patterns between 2014 and 2019, and the impact of bundled payments on the likelihood of receiving medical specialist care and the height of associated costs. **Results** The odds of medical specialist involvement declined over time for the 152,591 unique patients included in our study. Practices with a higher level of bundled payments had lower odds of medical specialist involvement. Medical specialist costs did also significantly decrease between 2014 and 2019, and patients in practices with the highest level of bundled payments had significantly lower medical specialist costs. When general practice costs were included however, healthcare costs per patient stayed the same, both over time and stratified by use of bundled payments. **Conclusion** Our findings suggest an association between bundled payments and specialized healthcare use, potentially facilitating the transition to primary care. While we found no evidence for costs savings, our findings do suggest that due to bundled payments more patients are actively monitored.

► **The impact of periodic updates to health benefits plan: access gains without cost savings?**

ESPINOSA, O., RODRIGUEZ-LESME, P., RODRIGUEZ, J., *ET AL*
2025

International Journal of Health Economics and Management 25(3): 317-336.

<https://doi.org/10.1007/s10754-025-09394-7>

Expanding explicit Health Benefit Plans (HBP) is a key strategy for achieving universal health coverage while maintaining financial sustainability. However, little is known about the broader effects of periodic updates to these plans on healthcare utilization, expenditures, and market dynamics. This study examines the impact of including new health technologies in Colombia's HBP covered by the Capitation Payment Unit (CPU) between 2012 and 2019, using administrative data and a difference-in-differences approach with multiple periods. Our results indicate that inclusion in the HBP-CPU led to a substantial increase in utilization and access, particularly in remote areas, but had mixed effects on expenditures. While the number of unique users and prescription frequency rose significantly, the cost per user remained stable for procedures but increased for medications, likely due to higher demand and market structures. These findings suggest that although periodic HBP updates enhance access and effective coverage, they do not necessarily generate cost savings. Strengthening health technology assessment processes, integrating price regulation policies, and implementing cost-containment mechanisms are essential for ensuring the financial sustainability of health systems that regularly update benefit plans.

► **Value-Based Payment in Medicare: Progress, Challenges, and Future Directions**

FIGUEROA, J. F., DUGGAN, C. E. ET JOYNT MADDIX, K. E.
2025

Journal of Health Politics, Policy and Law 50(6): 1059-1079.

<https://doi.org/10.1215/03616878-11995200>

Despite having the highest health care spending globally, the United States lags in key health outcomes compared to peer nations. Over recent decades, this concerning disconnect between spending and outcomes has spurred substantial national reforms focused on promoting "value" of care over "volume," prompting the development of numerous value-based payment models. In this analysis, the authors provide an overview of the experience with value-based payment efforts in the United States, particularly within the Medicare program. They outline and evaluate four

main value-based care paradigms: public reporting programs, pay-for-performance models, episode-based payment models, and population-based payment models. Across these models, they argue that there has been mixed success in achieving cost reduction and quality improvements. Although some episode-based and population-based models have shown modest savings, the overall efficacy of value-based care reforms remains suboptimal, and many models have yielded unintended consequences that have exacerbated existing health disparities. Considering this evidence alongside the current and emerging threats to value-based payment efforts, we identify several key areas for improvement across these models and discuss a path forward for strengthening value-based payment and delivery system reforms, highlighting key strategies to ensure that future value-based payment models achieve the goals of fostering high-quality, cost-effective, equitable care.

► **The Rise of Health Economics: Transforming the Landscape of Economic Research**

GSCHWENT, L., HAMMARFELT, B., KARLSSON, M., *et al.*

2026

Health Economics 35(1): 52-68.

<https://doi.org/10.1002/hec.70044>

ABSTRACT This paper explores the evolving role of health economics within economic research and publishing over the past 30 years. Historically, largely a niche field, health economics has become increasingly prominent, with the share of health economics papers in top journals growing significantly. We aim to identify the factors behind this rise. Using a combination of bibliometric methods and natural language processing (NLP), we classify abstracts to define health economics. Adapting NLP methods to evaluate the novelty, impact, and quality of academic papers, we demonstrate that the mainstreaming of health economics is driven by innovative, high-quality research, with two notable waves in quality ratings that highlight the emergence and impact of distinct subfields within the discipline. We find a strong positive correlation between citations and quality ratings, with health economics papers receiving fewer citations for their quality compared to other economics fields. Pandemic-related research received a high number of citations during 2020 and 2021; however, our findings indicate that this work was not systematically more novel or impactful than prior studies within the same subfield.

► **Fee cuts for radiology and low-value imaging**

HOWARD, D. H., HORNY, M. ET DILLENDER, M.
2025

International Journal of Health Economics and Management 25(3): 383-406.

<https://doi.org/10.1007/s10754-025-09398-3>

Based on the belief that fee-for-service reimbursement contributes to the overuse of costly medical procedures, policymakers have sought to cut payments for low-value services. Using a difference-in-differences model and Medicare claims linked with cancer registry records, we evaluate the impact of a large payment reduction for an imaging procedure commonly used in prostate cancer patients. We find that the payment cut did not affect imaging use, even in low-risk patients for whom imaging is not recommended. Our results suggest that supply may be relatively insensitive to fee levels when decisions about the use of a service are made exclusively by referring physicians, not the physicians who deliver and receive payment for it.

► **Maternity Care Bundled Payments In The Netherlands: Changes In Health Outcomes, Spending, And Care Delivery After 5 Years**

KLOOTWIJK, A., DE VRIES, E. F., HUANG, X., *et al.*
2025

Health Affairs 44(12): 1505-1513.

<https://doi.org/10.1377/hlthaff.2025.00685>

Bundled payments are increasingly used worldwide, yet long-term evidence remains limited, particularly in maternity care. This study evaluated five-year changes after bundled payments in maternity care in the Netherlands. Using a difference-in-differences design and 2008–21 nationwide data, we compared 22,307 pregnancies across six regions that adopted bundled payments in 2017 with 69,496 pregnancies in twenty matched control regions. Outcomes included maternity care use; maternal and neonatal health; and spending during pregnancy, childbirth, and the postnatal period. Bundled payments were associated with an 8.9 percent reduction in midwifery-to-obstetric transfers during delivery, a 1.1 percent decline in home births, and a US\$121 reduction in spending per pregnancy. Estimated effects varied across regions and over time. No changes were observed in maternal or neonatal health. These findings suggest that the shifts in clinical care processes through bundled payments

in Dutch maternity care modestly slowed spending, although they were likely not sufficient to improve health outcomes.

► **The Impact of Alteplase Coverage on Health Equity for the Treatment of Ischemic Stroke in the USA: A Distributional Cost-Effectiveness Analysis**

MAJDA, T., MEARN, E. S. ET KOWAL, S.
2025

Applied Health Economics and Health Policy 23(6): 1057-1072.

<https://doi.org/10.1007/s40258-025-00985-6>

OBJECTIVES: A distributional cost-effectiveness analysis (DCEA) was conducted to evaluate how alteplase for acute ischemic stroke affected overall health and disparities in the USA. **METHODS:** Using an existing, published, cost-effectiveness analysis, a DCEA was developed from a US payer perspective. The population was divided into 25 equity-relevant subgroups based on race and ethnicity (5 census-based groups), and county-level social vulnerability index (quintiles). Inputs for stroke outcomes, incidence and alteplase utilization varied across subgroups. Opportunity costs were estimated by converting total spend on alteplase into quality-adjusted life-years (QALYs) using an equal distribution across subgroups. Various scenarios explored the impact of health system changes to improve stroke care access. **RESULTS:** Alteplase treatment resulted in larger relative QALY gains in more vulnerable versus less vulnerable subgroups owing to increased acute ischemic stroke incidence and lower receipt of thrombolysis. Using an opportunity cost threshold of US\$150,000/QALY, alteplase was estimated to improve social welfare by increasing population health (45,606 QALYs gained) and reducing existing overall US inequities by 0.0001% annually. Results were robust across all levels of population inequality aversion and alternate opportunity cost thresholds. Health system scenarios that reduced care gaps promoted additional reductions in existing inequalities, because more patients with lower baseline health were eligible for treatment. **CONCLUSIONS:** Under current treatment patterns, this DCEA demonstrated that alteplase for acute ischemic stroke increased population health and improved health equity. It is critical to address existing care gaps to enable equitable access to alteplase across race, ethnicity and geography.

► **Prioritisation, risk selection, and illness severity in a mixed healthcare system**

OLIVELLA, P. ET VERA-HERNÁNDEZ, M.
2025

Journal of Health Economics 104: 103072.

<https://doi.org/10.1016/j.jhealeco.2025.103072>

We study the link between illness severity and the use of public health care services by the privately insured under a mixed healthcare system. Our theoretical model shows that this relationship depends on (1) the prioritisation implemented by public healthcare providers, (2) the stringency of the gatekeeping system, (3) the skewness of the patients' severity distribution, and (4) the private sector's risk selection behaviour. Our empirical analysis reveals that the relationship between illness severity and public healthcare use is U-shaped. As our theoretical model points out, the increasing part of the U-shape is not necessarily a consequence of risk selection by private healthcare providers, but could instead reflect prioritisation within the public sector. According to our analysis, individuals in both extremes of the illness severity distribution will benefit from additional resources to shorten public sector waiting times.

► **Oral health care's contribution to catastrophic spending in Canada: a descriptive study**

PROAÑO, D., ALLIN, S., ESSUE, B. M., *et al.*
2026

Health Policy OPEN 10: 10155.

<https://doi.org/10.1016/j.hpopen.2025.100155>

Background Oral health care (OHC) in Canada is largely financed through employer-sponsored insurance and out-of-pocket (OOP) payments and is generally excluded from its system of universal health coverage, although public financing will increase substantially with the introduction of the Canadian Dental Care Plan (CDCP). We generate estimates of catastrophic health expenditure (CHE) in Canada and assess the contribution of OHC-OOP spending to CHE between 2010 and 2019. **Methods** We examined the Survey of Household Spending from 2010 to 2019 by year and in pooled cross-sections and followed the WHO/Europe methodology to determine CHE. OHC-OOP spending was compared to medicines, medical products, outpatient care, diagnostic tests, and inpatient care. We assessed CHE and the share of OOP spending annually, nationally, provincially, across income quintiles and

presence of private insurance including oral health coverage. Results CHE dropped from 5% (2010) to 3.4% (2019) and was more common among lower income groups, those without private insurance and Québec residents. OHC was the second highest contributor to CHE (after medicines) especially among the lowest income groups. Having private insurance yielded a higher share of OOP spending among lower than higher income groups. Conclusions From 2010 to 2019, OHC-OOP spending was the second-highest contributor to CHE in Canada. Further monitoring is warranted to ensure financial protection is achieved for OHC after the full implementation of the CDCP.

► **Good intentions and the costs of inaction: Financial protection in Austria**

STEGNER, C. ET CZYPIONKA, T.

2026

Health Policy OPEN 10: 100159.

<https://doi.org/10.1016/j.hpopen.2025.100159>

Understanding the financial strain of health care costs borne by households is crucial for assessing the equity and affordability of a health system. Building on an already generous system, Austrian health policy has strived over decades to include more and more peo-

ple in its Social Health Insurance Schemes and to find ways to lower individual financial burden. Using data from the Austrian household budget survey for the years 2004/05, 2009/10, 2014/15 and 2019/20, this study investigates whether these efforts have been successful. Analyzing expenditures on various health care types, including medicines, medical products, outpatient care, dental care, diagnostic tests and inpatient care, our study aims to determine how the percentage of households experiencing catastrophic health expenditure (CHE) according to WHO definitions has changed over time. Logistic regression analyses were carried out to identify factors associated with CHE. The results reveal an increase in the prevalence of CHE from 2.1 % in 2004/05 to 3.6 % in 2019/20. Across all survey rounds, at least 60% of households experiencing CHE belonged to the poorest consumption quintile. Age, sex, educational attainment and employment status of the head of the household emerged as factors associated with CHE from the regression analysis. The observed rise in CHE is surprising given Austria's generous health system and the introduction of policies during the study period aimed at expanding the breadth and depth of coverage. It serves as an example for other countries that failing to tackle underlying structural problems in the healthcare system may counteract financial protection policies.

Environnement et santé

Environmental Health

► **Gender at the crossroads of mental health and climate change: A scoping review**

ABU, T. Z. ET ACHORE, M.

2026

Social Science & Medicine 388: 118708.

<https://doi.org/10.1016/j.socscimed.2025.118708>

The global intensification of environmental change and its resulting impacts on mental health are becoming increasingly evident, with gender mediating these outcomes. The primary goal of this scoping review is to highlight gender-specific mental health exposures and experiences in the face of climatic stressors. We further examine the role of climate responses in perpetuating climate-induced mental health impacts on men and women in existing literature. We synthe-

sized studies published since 2010 using six electronic bibliographic databases. We identified 3640 studies, which were imported into Covidence, and only 43 studies were utilized to perform our analysis. The studies were spatially categorized based on the Sustainable Development Goals (SDG) regions. Most of the studies were conducted in Australia and New Zealand (n = 9) and Central and Southern Asia (n = 9). Only seven studies explicitly indicated their guiding theoretical approaches or frameworks. Twenty-six studies focused on both men and women, fifteen on women only, and one on adolescents and children. No studies exclusively focused on men or included gender non-conforming, transgender, and non-binary individuals. A limited number of studies (13) applied longitudinal or time series approaches. Three main themes emerged: the gendered

direct and indirect (violence, economic, food and water insecurities) mental health impacts (suicidality, suicide, stress), determinants of climate-induced mental health impacts (e.g., structural and social determinants), and adaptation interventions (e.g., coping strategies at and beyond the individual level and agency). Gendered factors identified include men and women's work, physical and reproductive health, sociocultural expectations or constraints and gender-blind initiatives. Findings suggest a need for context and gender-specific interventions to mitigate the impacts of climate change, particularly on mental health outcomes.

► **Publish or Perish – do French hospitals disclose their greenhouse gas emissions for vertical differentiation?**

CLAVEL, N., MARRAULD, L., LESCHER-CLUZEL, M., *et al.*

2025

International Journal of Health Economics and Management 25(4): 487-507.

<https://doi.org/10.1007/s10754-025-09402-w>

French legislation requires large and medium-sized hospitals to publicly report their greenhouse gas (GHG) emissions. Yet, many hospitals fail to comply with this regulation, while others report voluntarily. The organizational drivers behind this behavior remain underexplored. This study examines whether hospitals disclose their GHG emissions as part of a broader strategy to differentiate themselves—similar to how they report patient satisfaction scores to signal quality. We explore whether carbon reporting is used as a vertical differentiation strategy in the French healthcare system. We used a mixed-methods approach. First, we analyzed national administrative data to test whether reporting GHG emissions is associated with reporting patient satisfaction scores. Second, we conducted semi-structured interviews with hospital managers to understand the motivations behind emissions reporting. Quantitatively, we found no significant association between the two types of reporting. Hospitals do not appear to use GHG emissions disclosure and patient satisfaction scores as part of the same signaling strategy. Qualitative findings confirmed that GHG reporting is primarily driven by internal factors such as executive leadership, process improvement, and organizational values, rather than external differentiation or patient demand. Carbon reporting in French hospitals is not currently used as a differentiation strategy. Stronger regulatory enforcement is needed to ensure compliance. In addition,

hospitals require support—through methodological guidance, training, and the development of dedicated sustainability roles—to integrate environmental performance into their management systems and contribute meaningfully to healthcare decarbonization.

► **The 2025 report of the Lancet Countdown on health and climate change**

ROMANELLO, M., WALAWENDER, M., HSU, S. C., *et al.*
2025

The Lancet 406(10521): 2804-2857.

[https://doi.org/10.1016/S0140-6736\(25\)01919-1](https://doi.org/10.1016/S0140-6736(25)01919-1)

► **Une seule santé et gouvernance des données : le rôle de l'Agence nationale de sécurité sanitaire de l'alimentation, de l'environnement et du travail**

VALLET, B. ET BRETON, P.

2025

Bulletin de l'Académie Nationale de Médecine 209(9): 1183-1188.

<https://doi.org/10.1016/j.banm.2025.09.001>

Résumé L'Agence nationale de sécurité sanitaire de l'alimentation, de l'environnement et du travail (Anses) déploie une approche intégrée « Une seule santé (*One Health*) » articulant santé humaine, animale, végétale et environnementale. Cette revue présente ses quatre missions — évaluer les risques, produire des connaissances, surveiller et alerter, et examiner les autorisations de mise sur le marché de produits réglementés — en montrant comment cette stratégie sert des objectifs scientifiques et politiques. D'un point de vue opérationnel, l'Anses incarne une gouvernance interministérielle des questions de santé et une approche interdisciplinaire adossée à des collectifs d'expertise indépendants et à des laboratoires de recherche et de référence. Sur le plan politique, l'approche *One Health* constitue un cadre d'action privilégié pour répondre à des défis systémiques : zoonoses, antibiorésistance, polluants persistants, changement climatique et justice environnementale. En appui de la montée en puissance de ce cadre, l'Anses s'implique dans l'exploitation des données numériques au profit des politiques publiques de santé au travers du *Green Data for Health* (GD4H), plateforme nationale visant l'interopérabilité et la valorisation des données environnementales et sanitaires au service de l'exposome, de la surveillance et de l'évaluation des risques. Le GD4H crée des ponts

entre données d'air, d'eau, de sols, d'alimentation et de santé, au bénéfice des décideurs et des territoires (plans d'action, prévention, aménagement). Cette revue propose des repères pour relier excellence scientifique,

transparence et participation des parties prenantes, au service d'une sécurité sanitaire élargie et d'une action publique plus efficace.

État de santé

Health Status

► **Impact of specialist palliative care on utilization of healthcare and social services at the end-of-life: a nationwide register-based cohort study**

AHTILUOTO, S. E., CARPEN, T. P., FORSIUS, P. T., *et al.*
2025

European Journal of Public Health 35(5): 828-834.
<https://doi.org/10.1093/eurpub/ckaf044>

Non-malignant diseases cause 60% of non-communicable diseases requiring palliative care, yet specialist palliative care services primarily focus on cancer. We investigated end-of-life healthcare and social services utilization among cancer and non-malignant patients, and, secondarily, access to specialist palliative care and its effect on services utilization. This retrospective, nationwide register-based study included all adults (n=38 540) who died from non-communicable life-limiting diseases in Finland in 2019, categorized into neurodegenerative (31%), other non-malignant (36%), and cancer (33%) groups. Hospital was the most common place of death (61%). Healthcare utilization substantially increased during the final weeks of life in all groups but remained highest in cancer patients. Social services utilization was highest in neurodegenerative diseases. Specialist palliative care contact was significantly (P<.001) higher in cancer (30.1%) compared to neurodegenerative (10.9%) and other non-malignant (7%) diseases. Early (>30 days before death) compared to late/no specialist palliative care contact significantly reduced emergency care contacts (47.8% vs. 52.2%) and hospitalizations in secondary hospitals (24.7% vs. 33.7%), and increased specialist palliative care ward (15.5% vs. 1.5%) and hospital-at-home (36.8% vs. 3.4%) utilization during the final month (P<.001). Healthcare utilization was high in all disease groups, highest among cancer patients. Hospital was the most common place of death. Specialist palliative care contact was rare in non-malignant diseases. Early contact

with specialist palliative care associated with lower emergency care utilization and secondary hospital inpatient care during the last month of life. These results highlight the necessity for timely equitable specialist palliative care services for all.

► **Diagnostic delay in rare diseases in the Campania region: addressing ageing, gender disparities, and the “postcode lottery effect” to reduce the patient odyssey**

CIRILLO, C., DURACCIO, R., FORDELLONE, M., *et al.*
2025

European Journal of Public Health 35(5): 862-866.
<https://doi.org/10.1093/eurpub/ckaf088>

Our study assessed the time to diagnosis of rare diseases (RDs) in Campania and whether there are determinants of diagnostic delay (DD). Demographic characteristics, date of first medical contact and diagnosis, disease macro-groups, and area of residence of patients were recorded. DD was calculated as the time elapsed (in years) from the onset of symptoms to the RD diagnosis date. Based on the Rare Disease Research Consortium consensus document, a time to diagnosis more than one year was considered DD. A multilevel logistic regression was performed. Seven thousand nine hundred and nine patients were included in the analysis; 47.4% were male. The mean DD was 3.4 years and 46% of patients experienced DD. Predictors of DD were female gender (OR 0.90, 95% CI 0.80–0.98, P<.005), age at diagnosis (OR 1.36, 95% CI 1.27–1.45, P<.001), and province of residence (residence in Naples vs. others; OR 0.80, 95% CI 0.73–0.88, P<.001). Immunological, connective tissue, digestive, genitourinary system diseases, and congenital malformations showed more DD than other disorders. Nearly half of the patients with RD experienced DD. The main

determinants of DD were female sex, older age at diagnosis.

► **Assessing the impact of chronic respiratory diseases on COVID-19 in-hospital mortality in the Italian population: a comparative study**

FATTORI, S., JONA LASINIO, G., ALFÒ, M., *et al.*
2025

European Journal of Public Health 35(5): 1058-1063.

<https://doi.org/10.1093/eurpub/ckaf149>

The COVID-19 pandemic has severely impacted Italy, leading to millions of cases and high mortality rates. Pre-existing chronic respiratory diseases may influence patient outcomes, and understanding their role is essential for improving healthcare strategies during such crises. This study analysed data from the Italian hospital discharge records database to explore the association between chronic respiratory diseases and in-hospital mortality due to COVID-19. Patients hospitalized in 2020 were studied, with exposure to respiratory diseases assessed based on hospitalizations between 2010 and 2019. Cox regression models were used to adjust for demographic and clinical factors, including age, gender, and comorbidity. Patients with pre-existing chronic respiratory diseases (n = 28 375, 13.9% of the total study population of 203 820) had a 71% higher risk (hazard ratio: 1.71, confidence interval: 1.54-1.90, P<.001) of in-hospital mortality compared to those without such conditions. Age, gender, the number of previous hospitalizations, and the Charlson comorbidity index were identified as key factors in mortality. Kaplan-Meier survival curves demonstrated significant differences in survival probabilities between exposed and unexposed groups across various age categories. Chronic respiratory diseases are associated with increased COVID-19 mortality, underscoring the need for targeted interventions in vulnerable populations to reduce the impact of future pandemics.

► **Basing healthcare decisions on value: patient-reported outcomes for patients diagnosed with breast cancer in a European cohort**

GOROSTIZA, A., CACICEDO, J., ALAYO, I., *et al.*
2025

European Journal of Public Health 35(5): 835-843.

<https://doi.org/10.1093/eurpub/ckaf064>

Improvements in breast cancer survival rate have been achieved through a variety of multimodal therapeutic approaches, which play a key role in the patients' healthcare pathway and their Patient-Reported Outcomes (PROs) from a Value-Based Healthcare (VBHC) perspective. This paper analyses differences in PROs of patients diagnosed with breast cancer according to their healthcare pathway. A cohort of 690 patients diagnosed with breast cancer between 2018 and 2020 at six European sites was used. PROs were assessed at baseline and 6 months using the International Consortium for Health Outcome Measures standard set. Archetypes defined by patient characteristics and treatment trajectories served as the basis for comparison. Multivariate linear regression models were used to analyse differences in PROs across archetypes. Functional scores generally worsened over 6 months, particularly in physical functioning, whereas emotional functioning improved. Archetypes undergoing mastectomy, with or without reconstruction, showed significant decreases in body image perception and satisfaction with breasts. Pain, fatigue, and peripheral symptoms were prevalent in most archetypes, with those receiving chemotherapy reporting the greatest symptom burden. Patients with in situ carcinoma and patients undergoing conservative surgery plus radiotherapy showed minimal deterioration. The use of PROs in a real-world setting enables the identification of differences across patient archetypes based on their therapeutic pathways. This information provides valuable insights for refining patient-centred care guiding VBHC strategies in oncology, developing of personalized care solutions, and facilitating Shared-Decision Making.

► **Rates and determinants of alcohol-drinking categories in France: a general population survey**

ROLLAND, B., DE TERNAY, J., HAESEBAERT, J., *et al.*
2025

European Journal of Public Health 35(6): 1255-1257.

<https://doi.org/10.1093/eurpub/ckaf147>

In an online-based survey conducted among a representative sample (n = 5000) of the French general population, the category of alcohol use, i.e. no-alcohol use (NAU: 18.5%), low-risk drinking (LRD: 59.4%), hazardous drinking (HD: 14.9%), and alcohol use disorder (AUD: 7.2%) was determined, using the AUDIT questionnaire. Multinomial logistic regression models, using LRD as the reference, showed that younger adults were more

likely to report NAU, but also HD, and AUD; women were less likely to report HD and AUD, while high occupational status was associated with reduced NAU and increased HD.

► **Interaction effects on health between perceived neighbourhood social cohesion and demographic changes: a longitudinal study**

SAUZET, O. ET SCHÄFER, M.

2025

Journal of Epidemiology and Population Health
73(6): 203154.

Perceived neighbourhood social cohesion is associated with better health in particular as a conveyor of social norms. Small-area demographic changes affect social structures related to health and so, could modify neighbourhood norms, lead to loneliness, or increased stress. Thus, demographic changes and perceived neighbourhood social cohesion are likely to interact in their relation to health. **Methods** We use longitudinal data from the German Socio-Economic Panel linked to demographic measures at county level to explore the association between an exposition to 5-year changes in the proportion of young and older adults with mental and physical health (MCS and PCS) and interaction effects with perceived neighbourhood social cohesion using random intercept models. Control variables include education, income, and relevant baseline measures. **Results** The analysis includes 21,239 persons up to 6 times in 399 counties. Five-year changes in the proportion of young and older adults as well as perceived neighbourhood social cohesion are associated to both PCS and MCS. Interactions between the change in older adults and perceived neighbourhood social cohesion are seen for mental health only in rural areas. In areas with larger decreases in the proportion of young individuals, the effect of perceived neighbourhood social cohesion on physical health was smaller than in areas with only small decreases (interaction term: 0.87(95 % CI [0.44, 1.31]). **Conclusion** Exposition to some demographic changes modifies the relationship between Perceived neighbourhood social cohesion and health making demographic changes a potential health stressor. This work needs to be further developed by considering smaller spatial scales and further understand the underlying mechanisms.

► **Long-term trends in mortality by living arrangements and the role of socioeconomic factors, Finland 1991–2020**

SUULAMO, U. K., REMES, H. M., TARKIAINEN, L. H., *et al.*

2025

European Journal of Public Health 35(5): 814-820.

<https://doi.org/10.1093/eurpub/ckaf068>

Recent decades have witnessed major changes in living arrangements, potentially impacting their well-established associations with mortality. However, research considering long-term trends in these differentials is scarce. We used individual-level register data on the total Finnish population aged 30 years and over from 1991 to 2020 to examine trends in the association between living arrangements and all-cause, as well as external and alcohol-related mortality. We calculated age-standardized mortality rates, quantified group differentials in absolute and relative terms, and assessed the contribution of socioeconomic factors with Poisson-models. Analyses were conducted separately for men and women in age groups 30–49, 50–69, and 70+. All-cause mortality was consistently lowest among men and women living with a partner. Highest rates were observed in the growing group of individuals living alone or with persons other than a partner or child, who experienced up to a five-fold excess mortality compared to those living with a partner and children. Mortality declined across all living arrangement groups over time. While absolute rate differences mostly narrowed, relative differences widened across all ages. Adjustments for socioeconomic factors somewhat attenuated mortality differentials, with their contribution increasing modestly by the end of the study period. In conclusion, over the past 30 years, relative mortality differences by living arrangement have increased at all ages for both men and women. These widening differentials pose a growing public health burden, particularly for the growing group of individuals living alone. Our results suggest that factors beyond socioeconomic differentiation are contributing to these trends.

Géographie de la santé

Geography of Health

► **Medical training pathways and underdoctored areas: a qualitative study of doctors working in areas that struggle to recruit and retain**

BREWSTER, L., CHEKAR, C. K., LAMBERT, M., *et al.*
2025

Health & Place 96: 103560.

<https://doi.org/10.1016/j.healthplace.2025.103560>

Some areas struggle more than others to recruit and retain doctors to provide healthcare services. Often, these areas are rural, coastal, remote, deprived or a combination of all these factors, compounding difficulties in access to healthcare; we refer to these areas as 'underdoctored'. This paper aims to describe experiences of working in underdoctored areas, with a focus on exploring why doctors work in these places to highlight what might enable future recruitment. It considers: the routes by which they arrived in an area and the drivers that facilitated those routes; the key stages in participants' lives at which transitions into the area were made; the agency – or lack thereof – that was involved in the choice to work in the area. While previous research has focused on factors driving workforce attrition, we work here to identify what encourages retention, particularly in areas that are known to have difficulties maintaining sufficient medical workforce. Drawing on interviews with doctors who work in these areas across case study sites, we conceptualise how there is a need to understand experiences of working in these areas to surface three intertwined elements – people, career, and place – within a doctors' place-life trajectory. We then explore how one or more of these elements might need to be compromised, how the acceptability of these compromises might change over time, and how the affordances associated with an underdoctored area can be negotiated and re-negotiated in order for those who move to an underdoctored area to want to stay. These findings have implications for improving recruitment and retention, health service provision, and ultimately, health inequalities in these underdoctored areas.

► **Vieillissement de la population, équipements, services et mobilités. Radiographie de trois départements de faible densité du sud de la France**

MALÉFANT, L.
2025

Géographie, économie, société 27(2): 183-210.

<https://doi.org/10.1684/ges.2025.38>

La population française vieillit et le nombre de personnes âgées dépendantes augmente. Cet article présente les résultats d'une recherche centrée sur le vieillissement de la population dans les territoires de faibles densités de trois départements : la Lozère, l'Aveyron et la Dordogne. En s'appuyant sur des données qualitatives et quantitatives, l'analyse suggère que le vieillissement de la population ne constitue qu'en creux une opportunité de « revitalisation » dans ces territoires. Parmi les enjeux liés à la prise en charge des personnes âgées dépendantes, certains sont accentués en milieu rural. Les questions de mobilité, d'accès au soin, aux équipements de services ou de logements sont souvent relayées par les acteurs locaux comme essentiellement problématique. Néanmoins, les situations sont contrastées selon l'échelle d'analyse, mais aussi d'un territoire à l'autre. Reste que la prise en charge des plus dépendants demeure perfectible partout. La doctrine de l'État les « confine » chez eux, c'est-à-dire dans des logements majoritairement inadaptés. De leurs côtés, les Ehpad se réinventent, mais pas assez vite au regard des besoins. Entre les deux, il y a peu de solutions innovantes en matière d'habitat et d'urbanisme.

► **Urban neighborhood factors influencing adolescent health and well-being: A qualitative study among adolescent boys in the city of Utrecht, the Netherlands**

ROELANDT, J., CZYMONIEWICZ-KLIPPEL, M. T., SIMONS, M., *et al.*
2025

Health & Place 96: 103566.

<https://doi.org/10.1016/j.healthplace.2025.103566>

Adolescent health and well-being is significantly influenced by the urban living environment. This study

examined what health and well-being mean to adolescents and how they perceive neighborhood factors as influencing them. Interviews with 15 adolescent boys from a low socioeconomic urban neighborhood in the City of Utrecht, the Netherlands, reveal that, according to these boys, doing fun things and spending time with friends and peers underpin their health. The adolescents indicated that such activities support adolescents' subjective well-being by providing opportunities to, *inter alia*, develop social contacts, explore and affirm their personal identity, and negotiate social belonging. The findings show that neighborhoods can

support or hinder adolescents' health and well-being by providing or limiting access to public and private spaces—such as outdoor recreation areas, organizations, sports clubs, and local stores and restaurants—where young people can gather, interact and potentially engage in paid work. Future health promotion efforts should focus on enhancing existing institutional resources, developing new ones, and improving financial support to provide all adolescents with affordable and accessible opportunities to promote their health and well-being through meaningful peer activities.

Handicap

Disability

► **How does disability affect incomes?
An empirical study on older European
workers**

BONDOUX, J., BARNAY, T., JUSOT, F., *et al.*
2025

Annals of Economics and Statistics(158): 45-80.
<https://doi.org/10.2307/48845128>

This paper studies the impact of the onset of disability on personal income. Using the Survey of Health, Ageing and Retirement in Europe, we compare income trajectories of individuals who experience disability with those who remain healthy over the same period. We hypothesize that the onset of disability reduces overall personal income, as the loss in wages is not fully compensated by disability-related benefits. To identify the causal impact, we combine a difference-in-differences approach with kernel propensity score matching, controlling for both observable and time-invariant unobservable individual characteristics. Our results confirm this hypothesis, showing a substantial decrease in personal income driven primarily by reduced wages. We further investigate heterogeneous effects by gender and the generosity of social welfare systems, showing that more generous welfare states mitigate income losses due to disability.

► **The role of financial difficulty
on the health and well-being of adults with
functional limitations that may require
long-term services and supports**

CHEN, L. ET KIETZMAN, K.
2026

Social Science & Medicine 388: 118725.
<https://doi.org/10.1016/j.socscimed.2025.118725>

Access to Long-Term Services and Supports (LTSS) is a big concern for many older adults and adults with disabilities who strive to live independently at home. People who have functional limitations that hinder completion of essential day-to-day activities are especially vulnerable to financial difficulty, which may further jeopardize their health and well-being. Using Pearlin's Stress Process Model, this study aims to understand how cumulative financial difficulties proliferate health and well-being among adults who are experiencing various types of functional limitations. This study used the first cycle of data (2019–2020) from the California Long-Term Services and Supports survey, merged with select data from the California Health Interview Survey (N = 2030). Descriptive and multivariable analyses were conducted to test hypothesized relationships. Among adults with functional limitations that may require LTSS, significant indirect associations with cumulative financial difficulties were found across measures of disability status and health and well-being. Experiences of financial difficulty, self-rated health and psychological distress varied by type of disability.

People with cognitive impairment experienced more financial difficulties, and more serious psychological distress. People reporting difficulties with activities of daily living or instrumental activities of daily living experienced lower levels of self-rated health. People with multiple types of disability experienced more financial difficulties, lower levels of self-rated health,

and more serious psychological distress. These findings can inform the development of targeted policies and practices that alleviate the economic challenges and disparities experienced by adults with diverse functional limitations and ensure that LTSS are more affordable and accessible for all.

Hôpital

Hospital

► **Hospital Patient Experience Worsened With the COVID-19 Pandemic, Especially for Older Adults, and Remains Worse than Before**

BECKETT, M. K., COHEA, C. W., SALIBA, D., *et al.*

2025

Medical Care Research and Review 82(6): 477–482.

<https://doi.org/10.1177/10775587251349053>

Adults age 75+ report worse inpatient experiences than patients 55 to 74. Older adults may have been especially vulnerable to changes such as family access and reduced staffing during the COVID-19 pandemic. We examined 2018–2023 Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys from 14,760,049 respondents discharged from 4,462 hospitals. We examined changes in an HCAHPS summary score (HCAHPS-SS), controlling for pre-pandemic quarterly and linear trends. HCAHPS-SS declined 4.1pp, a medium-to-large drop by Q3/2022, recovering only slightly by Q4/2023 (to –3.5pp). HCAHPS-SS decreased fastest for patients 75+ and least for maternity patients, even controlling for age. Differences by age may reflect older patients' greater need for instrumental support and differential impacts of visitor restrictions. Hospitals' quality improvement efforts should focus on understanding the need for patient support and on restoring prior patient experience gains. The failure to return to pre-pandemic levels points to the need to understand and address the residual factors that continue to alter patient experience.

► **Triage et urgences pédiatriques. Expérience de l'hôpital Necker-Enfants–Malades**

CHÉRON, G.

2025

Bulletin de l'Académie Nationale de Médecine 209(9): 1170-1174.

<https://doi.org/10.1016/j.banm.2025.04.027>

Résumé Le triage est un outil fonctionnel nécessaire à la gestion quantitative et qualitative des services d'urgences. Les échelles pédiatriques de triage ne sont pas satisfaisantes. Elles doivent être complétées par une évaluation médicale simultanée première étape de la démarche diagnostic. Le triage doit donc être le fruit d'un travail conjoint de l'infirmière d'accueil et du pédiatre.

► **Adjusting hospital reimbursements to the onset of a new disease: Lesson from Covid-19**

COPELLO, F., DATTARO, M., LEPORATTI, L., *et al.*

2025

Health Policy OPEN 9: 100148.

<https://doi.org/10.1016/j.hpopen.2025.100148>

The COVID-19 pandemic represented a significant shock to healthcare systems, which faced substantial challenges on multiple fronts. In addition to organizational and clinical issues, one important challenge that required attention was adapting hospital service reimbursement systems to address a new disease with initially unknown costs and consequences. In this paper, we quantify the gap between DRG tariffs and the actual hospitalization costs of COVID-19 cases, through

a comparison with pre-COVID-19 cases of respiratory tract infections, at San Martino Polyclinic Hospital, Genoa, Italy. We collected and analyzed a unique administrative dataset comprising Hospital Discharge Records (HDRs). We used propensity score matching to compare health outcomes and hospitalization costs of patients with confirmed SARS-CoV-2 pneumonia and patients in a control group of pre-COVID-19 patients with similar characteristics. We found that COVID-19 infection leads to a higher probability of being admitted to the Intensive Care Unit (ICU) and death, fewer days of hospitalization, increased hospital services, and increased costs of these services. Factors that increased hospitalization costs included female gender, age group 65–74 years, being admitted to ICU, death, increased length of stay (LOS), and the association between mechanical respiration DRGs and COVID-19 infection. In the period examined, DRG reimbursements were underestimated in severe COVID-19 cases requiring mechanical respiration. Knowledge of the factors that influence COVID-19 hospitalization costs may lead to a more comprehensive DRG tariff and, overall, to more effective management of financial resources in the event of future similar outbreaks.

► **La tarification à l'activité (T2A/GHM) entre paiement et régulation : tarifs, secteur et implications pour la santé publique**

MILCENT, C.

2025

Santé Publique vol. 37(4): 123-129.

<https://doi.org/10.3917/pub.254.0123>

Le financement hospitalier est un levier structurant des systèmes de santé, influençant l'organisation des soins, les comportements professionnels et l'équité d'accès. En France, la tarification à l'activité (T2A), instaurée entre 2004 et 2008, repose sur un financement forfaitaire par séjour, selon des groupes homogènes de malades (GHM). Conçue pour renforcer la transparence, l'efficacité et l'équité entre les secteurs public et privé, la T2A a néanmoins révélé des limites : complexité croissante, stratégies de codage, et tensions entre logique de performance et missions de service public. La T2A a évolué vers un outil multi-missions, mobilisé non seulement pour financer, mais aussi pour réguler l'offre de soins et produire des données épidémiologiques. Or, ces objectifs peuvent s'avérer contradictoires : les incitations financières au codage peuvent altérer la qualité des données, favorisant le

surcodage au détriment de la fiabilité des analyses de santé publique. Par ailleurs, un écart notable s'est creusé entre le système de classification complexe élaboré par les autorités de régulation et la version simplifiée utilisée en pratique par les professionnels de santé. Vingt ans après la mise en œuvre de la T2A, moins de 500 groupes (GHM), soit environ 20 % du total, suffisent à couvrir 80 % de l'activité hospitalière. Cette inadéquation contribue à une complexité inutile du système de tarification. De plus, le ratio tarifaire entre le secteur privé et le secteur public s'est stabilisé autour de 48 %, reflétant des différences structurelles persistantes. Cette divergence peut être attribuée au seul coût du personnel médical, mais peut également traduire des écarts organisationnels ou fonctionnels. Une évaluation rigoureuse de ces écarts est indispensable pour garantir un financement hospitalier plus équitable et pertinent. Cet article propose une lecture critique de la T2A, de sa genèse à ses usages actuels, et interroge sa capacité à répondre aux enjeux contemporains de soutenabilité, d'équité et de pertinence des soins.

► **The impact of pre-admission care on hospital mortality: results of an instrumental variable analysis from Italy**

MOSCONE, F., TOSETTI, E. ET VITTADINI, G.

2026

Health Policy 164: 105483.

<https://doi.org/10.1016/j.healthpol.2025.105483>

Background With healthcare spending projected to increase in the coming decades, the relationship between expenditure and health outcomes demands urgent attention. Objective This paper investigates the impact of health care spending on hospital mortality. We use data on 96,778 patients admitted for acute myocardial infarction (AMI) in the Lombardy region, Italy, in the years from 2007 to 2022 and combine them with information on expenditure on pharmaceuticals and outpatient visits made in the 12 months prior to hospital admission. Methods We adopt an instrumental variables approach to evaluate the causal impact of the total cost for pre-admission prescriptions and outpatient visits on hospital patient's mortality. Results We find that pre-admission healthcare, particularly pharmaceutical spending, has a significant impact on reducing mortality rates within hospitals, with a 10% increase in pharmaceutical spending leading to a reduction in mortality by around 3.0 percentage points, although this result varies depending on the age group and the type of infarction. Conclusions The findings

suggest that prioritizing pharmaceutical management can significantly reduce hospital mortality, highlighting a key area for healthcare optimization.

► **Hospital Finances, Operations, And Patient Experience Remain Stable After Oregon’s Hospital Payment Cap Was Implemented**

MURRAY, R. C., RYAN, A. M. ET WHALEY, C. M.
2025

Health Affairs 44(12): 1482-1489.
<https://doi.org/10.1377/hlthaff.2025.00682>

Hospital prices are an important driver of rising US health care spending, prompting states to explore policies to control hospital price growth. In October 2019, Oregon implemented a hospital payment cap, limiting hospital payments to 200 percent of Medicare payments for care provided to state employees. The policy generated \$50 million in annual savings for the state and its members, but its impact on hospitals’ finances, operations, and care delivery remains unclear. We used a synthetic difference-in-differences analytic design to examine the effect of Oregon’s payment cap on net patient revenues, patient care expenses, and operating margins. We found small and nonsignificant changes in Oregon hospitals’ revenues, expenses, and margins after implementation of the cap. Consistent with these findings, we observed limited changes in hospital operations and the patient experience of care. Overall, we found little evidence that Oregon’s payment cap disrupted hospital operations or care delivery.

► **Impact of midwifery-led units in Spain: lessons from the first 5 years**

PALAU-COSTAFREDA, R., ORUS-COVISA, L., VICENTE-CASTELLVÍ, E., *et al.*
2025

Health Policy 162: 105441.
<https://doi.org/10.1016/j.healthpol.2025.105441>

Background There has been a growing concern over rising medical interventions during childbirth, particularly caesarean sections, without corresponding improvements in maternal or neonatal outcomes. Midwifery-led units (MLUs) offer a model that promotes physiological birth while reducing unnecessary interventions. In Spain, where maternity care is predominantly hospital-based and obstetrician-led, the first public MLU opened in Catalonia in 2017. Its temporary closure

after five years offers a unique opportunity to assess its impact on interventions and outcomes. Objective To evaluate the MLU’s implementation and its effect on childbirth interventions within the unit and across the host hospital. Methods A retrospective cross-sectional trend study of childbirth data (2018–2023) from all public Catalan hospitals, and a retrospective cohort study of women contacting the MLU (2017–2022). Results MLU demand tripled between 2018 and 2022. Among 1286 attendees, 64.8 % were nulliparous and predominantly had low risk pregnancies. Half who planned an MLU birth began labour there, achieving 92.3% spontaneous vaginal births and 4.1 % caesareans. Hospital-wide, caesarean rates fell from 23.5% to 13.5% (2019–2021), while spontaneous births rose to 78.7%, suggesting a spill-over effect beyond the MLU. These trends reversed after closure in 2022. Conclusion Spain’s first public MLU was successfully implemented, safely reducing interventions and influencing wider hospital practices. Its closure and subsequent regression in birth outcomes highlight the need for sustained support and investment. MLUs can be an effective strategy for lowering intervention rates in highly medicalised systems, benefiting both unit users and the broader maternity care environment.

► **Seeking evidence of intersectional effects in emergency hospital readmissions of adults in England, 2016 - 2019**

SPENCER, J., WARD, R., BORTNOWSCHI, M., *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.

► **Unmasking and Rethinking Hierarchical Inefficiency in Healthcare Systems**

UNUIA, T. J., ANDREWS, A. ET KIMPTON, S.
2026

Social Science & Medicine 388: 118738.
<https://doi.org/10.1016/j.socscimed.2025.118738>

This study introduces a hierarchical Bayesian model that decomposes hospital inefficiency into components inherited from higher administrative tiers and those self-generated at the hospital level. This

approach extends traditional efficiency analyses (e.g., stochastic frontier models that assume inefficiency occurs only at the provider level) by capturing how inefficiency cascades from provinces and regions down to individual hospitals. The study applies the model to 942 hospital-year observations (2015-2019) from three Canadian provinces (Alberta, Nova Scotia, Ontario). The framework separates persistent technical inefficiency into three latent factors at the province, region, and hospital levels, quantifying inefficiency inherited from upstream governance and inefficiency generated at each level. Results show that inherited inefficiency from higher tiers accounts for roughly 73-76% of total persistent inefficiency across these provinces. This challenges the policy orthodoxy of targeting individual hospitals in isolation, as even hospitals with low self-generated inefficiency remain far from the efficiency frontier due to systemic constraints imposed by higher levels. This study offers the first empirical decomposition of inefficiency across a national health system's hierarchy. Although demonstrated in Canada, the approach is generalizable to any healthcare system with multilevel governance. It provides policymakers with a diagnostic tool to benchmark efficiency more accurately and to design system-level reforms, such as aligning funding flows, streamlining administration, and removing bottlenecks to achieve meaningful efficiency gains.

Inégalités de santé

Health Inequalities

► **Migrants' and immigrants' understandings of health and disease. Medical diversity in two diverse urban neighbourhoods**

BECKER, K., KRAAS, F. ET BUTSCH, C.
2026

Social Science & Medicine 389: 118851.
<https://doi.org/10.1016/j.socscimed.2025.118851>

Health and disease are understood in diverse ways, and im/migrants bring cultural backgrounds that shape explanatory concepts. These understandings influence health practices and may affect utilisation of healthcare institutions. Yet most research focuses on biomedical perspectives, offering limited insight into

how alternative medical, and supernatural understandings shape im/migrants' health practices. This study examined im/migrants in two German urban neighbourhoods (Bonn-Tannenbusch and Cologne-Mülheim), using a practice-theory approach (Schatzki 1996, 2002). Qualitative, semi-structured interviews revealed biomedical, alternative medical, and supernatural explanatory concepts that either travelled from countries of origin or were acquired after migration. We analysed the role of social groups, distinguishing between communities with shared migration backgrounds, other local communities, translocal communities, and healthcare institutions. From this, we developed a typology of four practice-shaping understandings of health and disease. We also examined medical diver-

sity, defined as the blending of different understandings and practices, finding it to be a common rather than exceptional feature. These results highlight the diversity of im/migrants' health understandings and explain why individuals adopt some practices while rejecting others.

► **Geographical and socio-economic inequalities in years of life lost across Norwegian municipalities and city districts in 2019: an ecological registry-based study**

BREIVIK, H., FORTHUN, I., KNUDSEN, A. K. S., *et al.*
2025

European Journal of Public Health 35(6): 1100-1106.
<https://doi.org/10.1093/eurpub/ckaf086>

Understanding local level impact of socio-economic and spatial disparities on health outcomes is crucial for informing effective public health interventions. This study examines the association between socio-economic factors, centrality, and premature mortality—measured as years of life lost (YLLs)—across Norwegian municipalities. We conducted an ecological, cross-sectional registry-based study across municipalities and districts, each with populations exceeding 1,000 as of 1 January 2019. Data on mortality, demographics, education, income, and centrality were sourced from Statistics Norway. All-cause YLLs were calculated by multiplying age-specific mortality numbers by aspirational life expectancy from the Global Burden of Disease 2019 life tables. Municipalities were divided into quartiles based on a composite socio-economic position (SEP) score that integrated education and income, and grouped into centrality categories. Mixed-effects negative binomial regression models, crude and adjusted for age categories and sex, evaluated both relative and absolute associations. The lowest SEP quartile, assessed with a composite SEP score, had a 15% higher YLL rate compared to the highest quartile [incidence rate ratio (IRR) = 1.15; 95% confidence interval (CI) = 1.07–1.24], amounting to an absolute difference of 2127 YLLs per 100 000 population. Similarly, the least central quartile exhibited a 15% higher YLL rate compared to the most central one (IRR = 1.15; 95% CI = 1.09–1.21), translating to an absolute difference of 2057 YLLs per 100 000 population. There are substantial inequalities in premature mortality across Norwegian municipalities, strongly linked to municipal SEP and centrality.

► **The prevalence of multimorbidity with mental and physical health for people who experience homelessness: a systematic review**

CHILMAN, N., SCHOFIELD, P., LAPORTE, D., *et al.*
2025

European Journal of Public Health 35(6): 1170-1177.
<https://doi.org/10.1093/eurpub/ckaf144>

Multimorbidity refers to the co-occurrence of multiple health conditions in a single individual. The objective of this systematic review was to synthesize and evaluate research on the prevalence of multimorbidity (including both mental and physical health conditions) for people who have experienced homelessness. MEDLINE, EMBASE, PsycINFO, Web of Science, and OpenGrey were searched for relevant studies between 1997 and 2025. Studies were included if the sample consisted of adults in high-income countries, where the exposure was current or former homelessness, and the outcome was multimorbidity including both mental and physical conditions. Random-effects meta-analyses were used to calculate pooled prevalence estimates. The studies were narratively synthesized, and quality assessed. The search retrieved 6043 papers, 30 of which were eligible for inclusion in the review. Most studies recruited participants from specialist homelessness services (n = 21). More than half of the study samples were over 75% male (N = 16). When excluding studies which applied non-probability sampling strategies, the pooled prevalence was 45% (95% CI, 25–66) for multimorbidity. There was a 34% (95% CI, 22–48) pooled prevalence for trimorbidity (co-occurring mental, physical, and substance/alcohol use conditions). High heterogeneity was observed across studies ($I^2 > 99\%$). To conclude, multimorbidity is highly prevalent for people who experience homelessness. There is a lack of research on multimorbidity for women who are or have been homeless, and for those who are not accessing specialist homelessness services. These findings demonstrate the need for the integration, collaboration, and co-ordination between services to support the multimorbid health needs of people who experience homelessness.

► **Social Inequality in Health as a political topic in Denmark in the 21st century**

DE MONTGOMERY, C. J. ET VRANGBÆK, K.
2026

Social Science & Medicine 389: 118807.
<https://doi.org/10.1016/j.socscimed.2025.118807>

This study traces the evolution of the '(in)equality in health' concept in parliament debates in Denmark from 1998 until 2024, exploring how the social determinants of health framework has been translated into policy discourse. We analyzed all parliament speeches employing the (in)equality in health concept between 1998 and 2024, and other significant documents of political intent during this period, including government platform papers, party programs and major political agreements. We then quantified the relative dominance of two distinct framings of health inequality by coding the parliament speeches using a large language model. We show that while health inequalities have increasingly been framed 'broadly' as a complex issue that notes the importance of social determinants, the practical policy issues connected with health inequalities have increasingly 'narrowed' in on the issue of healthcare access and quality. In a paradoxical translation of the social determinants framework, policymakers increasingly frame health inequalities as a complex phenomenon to undermine the use of legislation for structural prevention. The Danish case is illustrative of a dilemma that warrants strategic consideration among proponents of the social determinants of health framework, namely how to simultaneously broaden the policy conversation on health inequalities and prevent this broadness from being instrumentalized against action. We argue that one element of this balancing act could be to engage in more context-specific arguments for particular leverage points and to challenge the pursuit of evidence on 'what works' within politically defined boundaries of social change.

► **Health mediation mechanisms influencing healthcare utilization of underserved populations: a qualitative study in 2 districts in France**

ELODIE, R., LEILA, R., JUDITH, M. F., *et al.*
2025

BMC Health Services Research 25(1): 1437.
<https://doi.org/10.1186/s12913-025-13618-4>

Some populations remain chronically underserved to healthcare services because of poor housing conditions, lack of health insurance /administrative status, difficulties in French languages, disabilities, Health mediation, by promoting the ability of services to adapt their organization and supporting underserved populations in overcoming the obstacles encountered, could be an intervention to facilitate healthcare utilization by underserved populations. This study aimed to iden-

tify health mediation mechanisms that could influence healthcare utilization by underserved populations.

► **Cash Transfers and Health Outcomes: Evidence from Italian Municipalities**

FONTANA, S., GUCCIO, C., PIGNATARO, G., *et al.*
2026

Health Policy 163: 105494.
<https://doi.org/10.1016/j.healthpol.2025.105494>

Background Cash transfer programs are widely used to support household income and improve socioeconomic well-being. We examine the health impact of a nationwide transfer introduced in Italy in 2015, targeted at middle-income groups and providing up to €960 annually per beneficiary. Objective To assess the effect of the program on municipal all-cause mortality. Methods Leveraging panel data for all municipalities from 2010 to 2019, we exploit variation in treatment intensity induced by eligibility rules. Intensity is measured via per capita disbursements and share of beneficiaries. We estimate fixed-effects regressions with socio-demographic and economic covariates, regional time trends, and controls for spatial dependence. Results Increased transfer intensity is significantly associated with lower mortality: an additional €1 per capita corresponds to 0.004 fewer deaths per 1,000 residents, while a one-percentage-point increase in the beneficiary share corresponds to a 0.03 decrease in the same outcome. Heterogeneity analyses suggest stronger effects in municipalities with higher education levels and better healthcare access, indicating that these factors enhance the translation of income support into health gains. Conclusions Although not designed with health objectives, broad-based income support programs can yield measurable improvements in population health, particularly when complemented by education and healthcare investments.

► **Mothers' level of education and infant health. Causal effects of the introduction of a school reform in Norway**

GRYTEN, J. ET SKAU, I.
2025

Social Science & Medicine 386: 118632.
<https://doi.org/10.1016/j.socscimed.2025.118632>

We estimated the effects of mother's level of education on infant health by using data from a school reform in Norway. During the period 1960–1972, all

municipalities in Norway were required to increase the number of compulsory years of schooling from seven to nine years. This reform was used to create exogenous variation in the education variable. The control group comprised children who were born too early to have been exposed to the reform. The treatment group comprised children in the same municipality who were born late enough to have been exposed to the reform. The education data were combined with data from the Medical Birth Registry of Norway. We carried out analyses with several infant health outcomes: foetal, neonatal and infant mortality, mortality at the age of five or earlier, low birthweight, preterm birth and Apgar score. We found no effects of education on foetal and neonatal mortality, but significant effects for the other outcomes. The mother's level of education influenced the health of her infant through several channels, such as her health status, marital status, spousal education and income. We carried out several robustness tests, which supported our main results.

► **Social deprivation as a key driver of spatial disparities in end-stage kidney disease incidence**

HAMROUN, A., NIANG, A. T., OCCELLI, F., *et al.*
2025

Clinical Kidney Journal 18(9): sfaf266
<https://doi.org/10.1093/ckj/sfaf266>

Despite France's universal healthcare system, significant geographic disparities in the incidence of end-stage kidney disease (ESKD) persist. We hypothesized that social deprivation is a major driver of these spatial variations, independent of healthcare access and clinical risk factors, and that its contribution is stable over time. We conducted an ecological study including 102 226 incident ESKD cases across 34 830 municipalities in metropolitan France from 2012 to 2021, using data from the national REIN (Renal Epidemiology and Information Network) registry. A Bayesian hierarchical spatiotemporal model was used to estimate the association between ESKD incidence and ecological-level covariates: social deprivation [measured by the French European Deprivation Index (EDI)], diabetes prevalence, dialysis center accessibility and long-term exposure to PM2.5 (fine particulate matter, $\leq 2.5 \mu\text{m}$ in diameter). We estimated the population-attributable fraction of ESKD incidence for each factor under various counterfactual scenarios. Social deprivation was strongly associated with ESKD incidence [relative risk per 1 standard deviation increase in EDI: 1.10 (95%

credible interval 1.09–1.11)] and explained 34.7% of its spatial variability. The association was only partially mediated by diabetes prevalence [mediation proportion: 15.3% (95% confidence interval 12.5–18.2)]. The model incorporating all covariates explained 49.9% of the observed spatial heterogeneity. The effect of social deprivation remained consistent over time. Reducing deprivation in the most disadvantaged areas to the levels of the 5th, 25th and 50th percentiles of less deprived areas could have prevented an estimated 23 092, 17 450 and 13 601 ESKD cases, respectively, over the study period. Social deprivation is the leading ecological determinant of spatial disparities in ESKD incidence in France, with limited mediation by clinical factors and persistent effects despite universal healthcare. These findings underscore the need to address social determinants of health and to adapt kidney care delivery models to better reach socioeconomically disadvantaged populations.

► **To what extent does the onset of limiting health condition co-occur with poverty entries across European countries and educational groups?**

HIILAMO, A.
2025

Social Science & Medicine 387: 118630.
<https://doi.org/10.1016/j.socscimed.2025.118630>

The risks of poverty entry vary considerably across European countries, and within them by educational group. To what extent are these differences related to the association between health condition onset and poverty entry? This study analyses the associations and population contribution of the onset of limiting long-standing health conditions on the short-term risk of entry into objective and subjective poverty in 24 European countries. A series of logistic regression models fitted to the weighted EU-SILC data show that, net of key covariates measured the year before, the link between the onset of ill health and income poverty entry is weak, but the association between ill health and the risk of subjective poverty entry is substantial, particularly in Eastern European countries. Nevertheless, at the population level, only a small proportion of all poverty entries could be potentially attributed to this association. Similarly, poverty entry differences across educational groups could not be attributed to the differences in health conditions and their associations with poverty entries. Countries with strong associations between health and poverty

entries, such as Greece and Latvia, should develop their social insurance systems to both buffer individuals from the resources they lose due to health conditions and compensate them for their increasing needs due to these conditions.

► **The price of mobility: How migration shapes health outcomes in China**

HUANG, Q., ZHOU, J., XU, Z., *et al.*
2025

Social Science & Medicine 386: 118660.
<https://doi.org/10.1016/j.socscimed.2025.118660>

With the rapid pace of economic development, China has witnessed unprecedented population migration, which exerts a profound influence on migrants' health outcomes. This study used data from the 2023 Yangtze River Delta Health and Life Satisfaction Survey to explore the effects and underlying mechanisms of internal migration on health outcomes. The findings revealed that migration significantly worsened the migrants' health, and that the negative effects were more pronounced for interprovincial migration than for intraprovincial migration. Moreover, the study also found that greater social support could effectively buffer the negative health effects of migration, while the overall evaluation of the local healthcare services mediated this impact. These findings underscored the need for policymakers to reduce regional barriers, strengthen community cohesion, extend public services and social security to migrants, and promote their integration into residential communities through institutional reforms.

► **Income inequality modified adolescent substance use trajectories from 2018-19 to 2020–21: Findings from the COMPASS study**

HUNTER, S., RAI, U., CRANDALL-NICOLET, A. B., *et al.*
2025

Social Science & Medicine 386: 118635.
<https://doi.org/10.1016/j.socscimed.2025.118635>

Purpose Little is known about the structural determinants of adolescent substance use during times of crises. This study examined whether income inequality modified trends in adolescent substance use during the COVID-19 pandemic. Methods Adolescent (12–19 years) data (n = 22007) from the Cannabis, Obesity,

Mental health, Physical activity, Alcohol use, Smoking, and Sedentary behaviour (COMPASS) study were linked with census division (CD) data (n = 42) from the 2016 Canadian Census. Adolescents self-reported on their alcohol (including binge drinking), cigarettes, e-cigarettes, and cannabis use via questionnaire in 2018–19, and again in either 2019–20, or 2020–21. Income inequality was calculated at the CD-level of the school. Multilevel logistic regression models were used to examine whether income inequality modified trends in adolescent substance use through the inclusion of a cross-level interaction term (income inequality*time). Results The interaction term (income inequality*time) was significant for monthly use of cigarettes, e-cigarettes, and alcohol, indicating heterogenous trajectories based on CD income inequality. Students attending schools in less equal areas had higher odds of monthly cannabis use at baseline (OR = 1.49, 95 % CI: 1.24, 1.80), but the interaction term was not significant indicating homogenous trajectories. Income inequality was not associated with monthly binge drinking at baseline and did not modify trajectories over time. Gender stratified models revealed similar results for males and females except for e-cigarette use. Conclusion Income inequality may have modified adolescent substance use trajectories during the COVID-19 pandemic, with both increased and decreased likelihoods observed. More research investigating potential mechanisms is needed.

► **"Take away the greed of the private landlord housing market ... because that is killing people": Examining the political economy of housing and health inequalities in four English coastal towns**

MCGOWAN, V. J.
2026

Social Science & Medicine 388: 118707.
<https://doi.org/10.1016/j.socscimed.2025.118707>

Health inequities are avoidable and unjust differences in health arising from how society and the economy are structured. These inequalities are driven by vertical political and economic systems that prioritise economic growth over wellbeing. Yet, empirical research on health inequalities often focuses horizontally on people, places, and their inter-relationships. This research adopts a vertical lens to examine the structural processes driving geographical inequalities in health, framing housing as an extractive industry that contributes to ill-health and inequality. Drawing on comparative ethnography across four English coastal

towns, Hartlepool, Blackpool, Hastings, and Torbay, where deprivation, health and social inequalities are among the most severe in the country, the research involved 4-6 weeks of immersive fieldwork in each site during 2023. Data collection involved in-depth interviews, walking interviews, and focus groups with 140 people living/working in these towns, supported by participant observation, field notes, documentary analysis, and photography. This paper will focus on participants' discussions around housing as a major determinant of poor health and inequalities in their towns. Findings highlight vertical mechanisms such as 'Right-to-Buy' legislation, extractive wealth practices of private landlords, substandard housing conditions, financial strain, and housing insecurity in driving physical and mental ill-health. By highlighting the intersection of housing, the political economy, and health inequalities this study demonstrates the importance of 'scaling-up' our analyses to identify vertical processes which undermine horizontal efforts to reduce inequalities in health. Further examination of these dynamics, covering other determinants of health, is necessary to support the development of policies that go beyond mitigating health inequalities but also tackle the vertical structures that sustain them.

► **A scoping review of multiple deprivation indices in Europe**

MOGIN, G., GORASSO, V., IDAVAIN, J., *et al.*
2025

European Journal of Public Health 35(6): 1122-1128.
<https://doi.org/10.1093/eurpub/ckaf190>

Multiple deprivation indices (MDIs) measure community-level deprivation using various socio-economic indicators such as education level, unemployment rate, or family structure. With their growing use across Europe and the need to evaluate health impacts on vulnerable populations, this scoping review provides an overview of MDIs in the region. Insights into their construction methods will help provide guidance to researchers in developing future indices. This scoping review was conducted as part of the four-year research project funded through EU Horizon Europe—Burden of disease-based methods for estimating the socio-economic cost of environmental stressors (BEST-COST). We searched Medline, Embase, and Web of Science using terms covering deprivation in Europe. Articles meeting the inclusion criteria were reviewed to identify MDIs and their methodologies. Those including a health indicator were excluded from the study. From 163 articles

meeting our inclusion criteria, 18 MDIs were identified. The number of underlying indicators ranged from 4 to 22 across MDIs. Most indices were built for small geographical areas, such as municipalities, districts, or census tracts. Ten indices applied weights derived from statistical methods such as principal components analysis, while the other eight applied equal weights and calculated the index as a simple arithmetic sum or mean composite score. The review highlights high variability in MDI methodologies and emphasizes that aligning MDI selection with the context and objectives of a study. Furthermore, due to the vast cultural and geographical diversity across European countries, developing a Europe-wide index requires careful consideration of the methodologies to be employed.

► **Testing the Healthy Immigrant Effect on Youth Alcohol Use: A Longitudinal Study**

MUYINGO, L., MACKINNON, S., SHERRY, S. B., *et al.*
2026

Social Science & Medicine 389: 118823.
<https://doi.org/10.1016/j.socscimed.2025.118823>

Purpose The healthy immigrant effect (HIE) is a phenomenon observed in developed countries in which recent immigrants report better health compared to the majority population. The purpose of the present study was to examine the HIE by comparing two measures of alcohol use over time across three adolescent groups of differing immigration statuses. **Methods** We examined the HIE by comparing alcohol use quantity and drinking onset longitudinally from grades 7-11 across 1.5, 2nd, and 3+ immigrant generation status youth (N=2621-3353). Overall, 38.10% participants completed 5 waves, 30.08% completed 4 waves, 12.86% completed 3 waves, 9.13% completed 2 waves, and 9.27% completed one wave. **Results** Significant differences were found between immigration generation statuses consistent with the HIE: individuals of 1.5 immigrant generation status reported lower drinking quantity and later onset drinking compared to individuals of 2nd and 3+ immigrant generation status. Additional analyses revealed socioeconomic status (SES) and alcohol norms to be predictors of alcohol use. Differences in immigrant youth alcohol use quantity (but not onset) may be partially explained by group differences in SES and alcohol norms. **Conclusion** Results suggest recent immigration status is protective against alcohol use in youth. Future research should examine moderators to the HIE including country-of-origin.

► **Migration trajectories, uncertainty and health: a conceptual review**

RAST, E., DETERING, B., ROHLEDER, S., *et al.*
2026

Social Science & Medicine 390: 118792.

<https://doi.org/10.1016/j.socscimed.2025.118792>

Background Migration trajectories are complex, non-linear movements, including periods of immobility, secondary migration, return and psychosocial changes. A defining feature of these trajectories is uncertainty, resulting from incomplete place-based knowledge and the unpredictable future. We examined how migration trajectories and associated uncertainties have been conceptualised and operationalised in health-related research. Methods We conducted a conceptual review with systematic searches in Medline, Embase, Web of Science, and Global Index Medicus. After duplicate screening, we extracted information on concept definitions, operationalisations and links to health. Uncertainty factors were categorised and mapped followed by a narrative synthesis (PROSPERO protocol: XXX). Results From 3836 titles after deduplication, 66 were synthesised which used various designs and mostly focused on forced migrants in high-income countries. Concept definitions and operationalisations varied strongly. Phase models outlining consecutive migration stages were frequently applied, while sometimes also considering non-linearity of trajectories. Uncertainty was mostly mentioned regarding legal status, followed by uncertainty of the future, 'general' uncertainty of migration processes, and uncertainty of social relations. Fewer studies considered uncertainty of economic, healthcare, and societal factors. Uncertainties were mostly associated with adverse mental health. Conclusions The review illustrates a plethora of uncertainties along migration trajectories, with many studies showing negative psychological impacts of legal uncertainty. Current theorisations do, however, not tap the concept's potential to generate health-related knowledge across migration trajectories, particularly regarding mobility regimes, conceptual meanings and modal time. Avenues for further research include considering positive health outcomes, examining how mobility regimes affect 'possible futures', and enhancing methods for studying uncertainty.

► **Association Between Socioeconomic Disadvantage and Low-Value Care in Acute Care Hospitals in Japan: Cross-sectional Study**

SATO, S., YASUNAGA, H., MATSUO, Y., *et al.*

2026

Health Policy 163: 105479.

<https://doi.org/10.1016/j.healthpol.2025.105479>

Background Low-value care offers little clinical benefit and contributes to inefficient healthcare utilization. Although socioeconomic disparities in healthcare access are well documented, data on low-value care among disadvantaged inpatients remain limited. Objective To examine the association between neighborhood-level socioeconomic status (SES) and the proportion of low-value care services in Japanese inpatient settings using the area deprivation index (ADI) as a proxy for SES. Methods We conducted a cross-sectional study using a nationwide inpatient database from 920 hospitals in Japan between April 2022 and March 2023. Hospitalizations of patients aged ≥ 18 years receiving one of 12 selected low-value care services were included. The outcome was whether a service provided during hospitalization was classified as low-value based on established algorithms. Patients from deprived areas (top 10% ADI) were compared with those from non-deprived areas, adjusting for patient case-mix and hospital fixed effects. Results Among 524,705 hospitalizations (42.3% female; mean age, 69.9 ± 15.5 years), 33,271 (6.3%) were classified as low-value care. After adjustment, patients from deprived areas had a higher proportion of low-value care than those from non-deprived areas (6.6% vs. 6.3%; adjusted difference, +0.2 percentage points; 95% CI, 0.03 to 0.5; $P = 0.02$). Subgroup analyses showed stronger associations among patients aged ≥ 65 , females, and those treated in non-academic hospitals. Results remained consistent after accounting for hospital fixed effects. Conclusions Patients from disadvantaged areas are slightly more likely to receive low-value inpatient care than are those from non-disadvantaged areas. Older adults, women, and patients treated in non-academic hospitals appeared more affected.

► **Devolution, Health and Health Inequalities in Greater Manchester**

SWEENEY, N. P.

2026

Social Science & Medicine 389: 118763.

<https://doi.org/10.1016/j.socscimed.2025.118763>

Improving health outcomes and reducing health inequalities are core objectives for policymakers globally. In recent years, devolution has been argued to improve the delivery of health services, but empirical evidence remains limited. I examine the Greater Manchester Health and Social Care Partnership, introduced in April 2016, to estimate the effect of increased sub-national powers on health outcomes. Using Census data from 2011 and 2021, I construct a panel microdata set of 1,326 Greater Manchester (GM) neighbourhoods and propensity score matched non-GM neighbourhoods based on 2011 pre-treatment characteristics. I then estimate ordinary least squares and difference-in-differences models, assessing parallel pre-trends using Census 2001 data. I find that post-devolution neighbourhoods in Greater Manchester reported a +0.45 percentage point higher than expected share of residents in good health (95% CI [0.06, 0.84]). These improvements are concentrated in the least healthy neighbourhoods, which experienced a +2.27 percentage point gain relative to their matched controls (95% CI [1.70, 2.84]). The results provide new evidence on the performance of devolved health policy, informing research on the role of healthcare in reducing health inequalities and shaping wider policy debates on devolution.

► **An index of multiple deprivation in Sweden: measuring area-level socio-economic inequalities**

VAN DER VELDE, L., SHABAAN, A. N., MATTSSON, M.,
et al.

2025

European Journal of Public Health 35(6): 1107-1114.

<https://doi.org/10.1093/eurpub/ckaf138>

Area-level measures of deprivation in Sweden often rely on limited socio-economic indicators, such as income or education. To address this, we developed the Index of Multiple Deprivation in Sweden (IMDIS) to capture a multitude of explanatory factors for socio-economic inequalities and the distribution across small areas in Sweden. The IMDIS is a compositional index constructed for small areas in Sweden in 2015 and combines 15 indicators across 4 domains (Housing, Employment, Income and Capital, and Education) into an overall deprivation score. Indicators were selected and spatially smoothed to mitigate the effect of small numbers and increase robustness. Domains were constructed using a weighted average of underlying indica-

tors, allowing detailed examination of the significance each domain or indicator has in small areas, and were further combined using explicit weights. All areas were subsequently ranked from the 1st least to 5984th most deprived area. For each area, we generated three key outputs: a score, a rank, and assignment to a deprivation decile. The IMDIS showed high internal consistency and revealed stark geographic inequalities in deprivation. The most deprived areas were concentrated in urban regions, particularly Stockholm, Gothenburg, and Malmö. Housing deprivation was more prominent in urban areas, while educational deprivation was more prevalent in rural and peripheral regions. The IMDIS offers a comprehensive measure of multiple deprivation at the small-area level in Sweden. Its domains and indicators can be used individually or combined to identify inequalities in vulnerable areas and explore geographic patterns, supporting a deeper understanding of social disparities.

► **Prévalence des troubles psychiques et déterminants du parcours de soins chez le public migrant précaire : données d'une revue de la littérature**

VIEIRA, L. ET PONTONNIER, A. L.

2025

L'information psychiatrique 101(8): 633-639.

<https://doi.org/10.1684/ipe.2025.2934>

La santé du public migrant, fragilisée par des parcours de vie traumatiques et des conditions d'accueil difficiles, est préoccupante. Pour autant, son accès aux soins apparaît limité. Mieux connaître les facteurs influençant le parcours de soins de ce public est nécessaire dans une démarche de santé publique. L'objectif de cette étude est d'estimer la prévalence du trouble de stress post-traumatique (TSPT) au sein de cette population et d'identifier les facteurs impactant le parcours de soins via une revue de littérature réalisée à partir de cinq bases de données. Cinq grands thèmes se dégagent : difficulté à estimer la prévalence du TSPT au sein de ce public, vulnérabilité des femmes, impact des conditions de vie post-migratoires sur la chronicité du trouble, identification de freins et de leviers dans le parcours de soins. Considérer ces éléments pour penser des dispositifs de soins adaptés est indispensable.

► **The association of sex and socioeconomic status with multimorbidity: results from the UK Biobank**

YOUSSEF, D. M., HARRIS, K., GROBBEE, D. E., *et al.*
2025

Journal of Epidemiology and Population Health
73(5): 203134.

<https://doi.org/10.1016/j.jep.2025.203134>

Introduction Multimorbidity, defined as the coexistence of two or more chronic diseases, is common. It is not well-understood how multimorbidity differs by sex and socioeconomic status. **Methods** Cross-sectional data from the UK Biobank in 2006–10 were used. Socioeconomic status was determined from area-based deprivation and individual education level. Multimorbidity was defined as having two or more chronic diseases, identified through linked hospital-admission data between 1995 and 2022. Modified Poisson regression was used to estimate age-adjusted prevalence relative risks (RRs) and women-to-men ratio of RRs with 95% confidence intervals (CIs) for association of socioeconomic status with multimorbidity. **Results** A total of 502,364 individuals (54% women) were included. Forty two percent of women and 48% of men had multimorbidity, with the most common disease combination being cancer and hypertension, and hypertension being the most common single condition in both sexes (68% of men and 58% of women). The age-adjusted risk of multimorbidity was higher in men than in women (RR, 1.12, 95% CI, 1.11–1.13). Compared to those in the least deprived areas, the age-adjusted risk of multimorbidity in the most deprived areas was 1.36 (95% CI, 1.33–1.38) in women, and 1.29 (95% CI, 1.27–1.31) in men, with a women-to-men ratio of RRs of 1.05 (95% CI, 1.02–1.08). **Conclusion** Multimorbidity is more common in individuals with lower socioeconomic status, and men have a higher age-adjusted risk than women. The association between area-based deprivation and multimorbidity is stronger in women than men, emphasizing the need for tailored interventions that address both sex and socioeconomic disparities in multimorbidity.

► **Unequal high streets? A spatial analysis of inequalities in health-related amenities in England from 2014–2024**

ZIED ABOZIED, E., MUNFORD, L., TODD, A., *et al.*
2026

Social Science & Medicine 390: 118863.

<https://doi.org/10.1016/j.socscimed.2025.118863>

There are persistent inequalities in health-related behaviours in England which are stratified by region and deprivation. These are influenced by the interaction of people with places they live in, over and above individual risk factors. The amenities available on high streets is one such aspect of place but to date, its role in shaping health behaviours has been under examined. Our study presents a novel analysis into health-related amenities and change in availability between 2014 and 2024. We used geographic data analysis and statistical modelling of Ordnance Survey Points of Interest data to describe the association between health-related amenities, area level deprivation and region across England. We found that there were significant inequalities in amenity availability by deprivation over the past decade. The most deprived areas were more likely to gain a takeaway (OR1.56[1.28,1.91]), a bookmaker (OR2.14[1.64,2.79]), or a vape shop (OR2.11[1.68, 2.66] and more likely to lose a supermarket (OR1.95[1.62,2.35]) or a public toilet (OR1.34[1.12,1.62]), compared to the least deprived areas. These patterns were similar on a regional level - the North was more likely to gain a takeaway (OR1.65[1.44,1.90]), a bookmaker (OR1.40[1.18,1.66]), a pawnbroker (OR1.72[1.23,2.40]) or a vape shop (OR1.30[1.11,1.51]) compared to the South. Our findings indicate that the most deprived areas and regions are gaining potentially health-harming amenities and losing health-conducive ones. Through this analysis, we argue that amenities that facilitate health behaviours on high streets are influenced by political and economic drivers of health inequalities and therefore require political decisions to manage, rather than individual behaviour change.

Health Policy**► Divergences et convergences idéologiques sur les dépenses sociales et de santé**JACQUES, O., BEN JELILI, E. ET ARPIN, E.
2025**Sociologie et sociétés 56(1-2): 287-316.**
<https://doi.org/10.7202/1121164ar>

Cet article se penche sur l'impact de l'orientation idéologique du gouvernement sur les réformes de politiques sociales et de santé dans les pays de l'OCDE. Nous assemblons une base de données regroupant 21 pays de 1970 à 2019 et proposons un nouvel indice de démarchandisation des soins de santé. Nous appuyant sur le concept de partage et de concentration des risques sociaux, nous démontrons que l'idéologie des partis politiques a plus d'impact sur les politiques sociales que sur les politiques de santé. Contrairement à notre hypothèse, les partis de droite ne sont pas plus susceptibles de favoriser des réformes laissant une place plus grande au privé dans les soins de santé, sauf aux États-Unis où l'on observe une forte polarisation partisane. L'idéologie du gouvernement n'influence pas davantage les réformes de santé dans les systèmes de santé nationaux où l'État peut plus facilement imposer des changements que dans les systèmes assurantiels.

► LGBTQ+ Health, Policy, and Politics: Advances, Challenges, and Potential OpportunitiesNGUYEN, K. H., MENARD, L., ALLEN, H., *et al.*
2025**Journal of Health Politics, Policy and Law 50(6): 901-920.**
<https://doi.org/10.1215/03616878-11995168>

The landscape of politics and policies that impact the health and well-being of lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) people in the United States has evolved substantially in the last 50 years. Tracing its roots back to the 1960s, the LGBTQ+ rights movement has often relied on health as an organizing principle to advance progress through advocacy, research, and public policy. In this article, the authors present the evolution of LGBTQ+ data collection and health policy research—with particular atten-

tion to nationwide marriage equality, the Affordable Care Act, and access to transgender-inclusive health insurance coverage—and then discuss the possible future trajectories of LGBTQ+ inclusion and equity. The authors also reflect on the pendulous trajectory of LGBTQ+ rights and progress, which have oscillated between incremental advancements and reactionary periods of regression. Ultimately, through decades of grassroots organizing, advocacy, legal battles, and shifts in public opinion, the LGBTQ+ community's visibility and acceptance have grown. Concurrently, the body of LGBTQ+-specific health research has proliferated and has informed policies that have meaningfully improved the health and well-being of LGBTQ+ people. Although the country is currently in an era of substantial policy retraction, the authors remain hopeful about the next 50 years.

► Same as It Ever Was? Persistence and Transformation in US Health Care Policy.OBERLANDER, J.
2025**Journal of Health Politics, Policy and Law 50(6): 877-900.**
<https://doi.org/10.1215/03616878-11995208>

US health care seems stuck in an endless cycle of crisis and failed (or when it does happen, disappointing) reform. The United States is, as it was 50 years ago, still bedeviled by high costs, a large uninsured population, and fragmented, inequitable financing arrangements. Yet the persistence of those problems obscures consequential shifts in US health politics and policy over the past five decades, including the expansion of insurance coverage, the rise of private insurance within public programs, and the advent of government cost-control measures as well as major changes in private insurance. This article explores the sources and consequences of these transformations as well as their limits.

► **Health workforce resilience in the age of polycrisis: a framework to support health workforce policy and planning**

ONVLEE, O., JACOBS, E., TROMP, N., *et al.*

2026

Health Policy 164: 105500.

<https://doi.org/10.1016/j.healthpol.2025.105500>

Background Many countries face prolonged health workforce crises, marked by shortages, maldistribution, skills mix imbalances and attrition. When workforces are overstretched, they become more vulnerable to external shocks and chronic strains, including infectious disease outbreaks, climate-related effects and political instability. This is particularly concerning as an emerging global “polycrisis” means such external pressures increasingly interact and amplify one another in unpredictable ways. Strengthening health workforce resilience must therefore become a priority for policy and planning. **Objective** To introduce a resilience lens for health workforce policy and planning. **Methods** This conceptual paper synthesises literature from health workforce and systems research, resilience, and complex adaptive systems theory, complemented by practical insights from workforce planning and governance. **Results** The paper presents the Health Workforce Resilience framework, which illustrates how the multilevel nature of health workforce resilience connects individual health workers, teams and organisations, and the national health workforce level. It shows how shocks and long-term pressures ripple through these interconnected levels, affecting the capacity, composition, and performance of the workforce. **Impacts and responses** at one level can amplify or dampen effects at others. The framework highlights two critical interfaces: the workforce–community interface, capturing how societal, economic, and security conditions shape workforce motivation, performance, and retention, and the workforce–governance interface, reflecting how institutional arrangements, policies, and decision-making processes enable or constrain system responses. **Conclusions** Adopting a resilience lens underscores the need to view workforce planning as a systems approach that emphasises anticipatory, needs-based planning and integrates political, social, and contextual realities to strengthen workforce resilience under pressure.

► **L’efficacité des interventions de santé publique en France : un retour en arrière ?**

RIDDE, V., ALLA, F., CAMBON, L., *et al.*

2025

Santé Publique 37(4): 119-122.

<https://doi.org/10.3917/spub.254.0119>

La santé publique française institutionnelle a relancé le débat sur la notion de données probantes. En 2025, elle vient de rendre public un répertoire des interventions jugées efficaces par un comité d’experts. La preuve d’efficacité est fondée sur la qualité, la solidité et la fiabilité des données scientifiques. Ce répertoire va inciter et orienter les financements publics vers certaines interventions. Dans ce commentaire, nous montrons que cette vision réductrice de l’efficacité s’inscrit dans l’histoire d’une santé publique influencée par la recherche clinique et épidémiologique. Pourtant, il y a 20 ans, la France avait déjà organisé une réflexion solide sur la notion de données probantes et d’efficacité afin de s’inscrire dans un virage mondial sensible à la diversité des connaissances et de la promotion de la santé. En effet, les interventions de santé publique sont par essence complexes et leur efficacité dépend notamment de leurs fondements théoriques et de leurs adaptations aux multiples contextes locaux de leur mise en œuvre. La vision portée par la construction de ce répertoire invisibilise la diversité des savoirs, omet l’indispensable interdisciplinarité et ignore les personnes concernées. Il s’agit donc d’un retour en arrière incohérent avec le contexte actuel et l’évolution des connaissances scientifiques sur l’évaluation des interventions complexes

► **A scoping literature review of rehabilitation policy recommendations during the COVID-19 pandemic in the WHO European Region**

THOMAS, C., GOSLING, J., ASHTON, R. E., *et al.*

2026

Health Policy 163: 105477.

<https://doi.org/10.1016/j.healthpol.2025.105477>

Background As with other frontline healthcare services, the delivery of rehabilitation services has been greatly affected by the COVID-19 pandemic with many services suspended, despite WHO’s mandate that rehabilitation is an essential service. **Objective** This review aimed to provide an overview of policy responses that were taken across the WHO European Region to identify systems and processes that helped to inform and

shape decisions pertaining to rehabilitation during the COVID-19 pandemic. Methods A scoping literature search was conducted according to PRISMA-ScR guidelines and prospectively registered on Prospero (ID: CRD42024550641). Cinahl, Cochrane, PubMed and Scopus databases were searched from inception to February 2024. Eligibility criteria for selecting publications: Published work that includes any policy documents that informed rehabilitation during the COVID-19 pandemic in any of the 53 World Health Organisation European member states. Search results were extracted using the PESTLE heading framework in Microsoft Excel. Results Seven publications comprising seven policy documents from Italy (N=2), England (N=2) and the United Kingdom (N=3) were included in this review. Five key areas were identified in response to COVID-19 and rehabilitation: 1) government direction, 2) funding, 3) education, 4) telerehabilitation, and 5) social distancing and isolation. Conclusions Our study's findings demonstrate a dearth of published government policy documentation referring to rehabilitation in response to the COVID-19 pandemic. This lack of published documents indicates that rehabilitation is not considered an essential health service during emergency response. Research should investigate the systems and processes of key decision-makers to inform future rehabilitation pandemic preparations.

► **Places of end-of-life care and death in health policies of four countries (EOLinPLACE Project)**

VAN DE BEEK, S. H., GOMES, B., ECKELS, K., *et al.*
2025

Health & Place 96: 103534.

<https://doi.org/10.1016/j.healthplace.2025.103534>

Background Place of death and its concordance with patient preference is a key indicator for end-of-life care, studied cross-nationally and flagged as a priority by the OECD. However, it is unclear if and how 'place' is considered in health policy in relation to end-of-life care. This study aims to examine if and how health policies in different nations consider places of end-of-life care and death. Methods We conducted a comparative qualitative study across the US, the Netherlands, Portugal, and Uganda, of health policy documents following the READ (i.e., Ready materials, Extract data, Analyze data, Distill findings) systematic approach for document analysis in health policy research. Documents were analyzed using directed content analysis following Hsieh and Shannon (2005). Timelines for document

publication were country-specific, based on local health policy developments relevant to end-of-life care in the last two decades. Backdates ranged from 2001 in Uganda to 2015 in the Netherlands; the most recent publication year was 2024 for all countries. Findings We identified 89 policy documents relevant to end-of-life care mentioning preferred or actual places of end-of-life care or death. The first topic was 'Narratives around places', where home was prioritized while inpatient facilities were most problematized. A second topic 'Policy measures acting on places' included: i) Availability of services across places, where the rural-urban divide, workforce shortages, waitlists and financial considerations challenged availability of end-of-life care across places; and ii) Professional expertise vs. community empowerment, which highlighted a key tension in the extent to which countries invest in professional expertise versus community empowerment. Conclusions While improving care at home is prioritized with evidence-based reasons to support it, our study shows that policymakers overlook the potential benefits of other care settings and flexible care solutions that promote continuity of care. This comparative analysis unveiled implications to improve end-of-life care across care settings.

► **An Inventory of Policy Levers to Reduce Low Value Care: Results of a Rapid Scoping Review**

WARKENTIN, L. M., TJOSVOLD, L. ET BOND, K.
2026

Health Policy 164: 105508.

<https://doi.org/10.1016/j.healthpol.2025.105508>

Background : The continued use of low-value health care consumes system resources and creates unnecessary risk. There are numerous policy levers available to improve appropriateness of care, but a supporting tool is needed to allow for characteristic and evidence comparison. Objective : Develop an inventory which catalogues policy levers which support the reduction of low-value care, alongside their effectiveness evidence and implementation factors. Methods : Information on relevant levers was identified through searches in Medline, Cochrane Library, and Google Scholar, with additional targeted searches. An Excel-based inventory was developed with a list of levers, their descriptions, effectiveness outcomes, and implementation considerations. Filters were developed to help identify levers based on key characteristics. The inventory was refined through presentations to and feedback from

key stakeholders. Results : The inventory includes 53 levers which may influence clinician or patient behaviour, service provision, fiscal policies, and populations or organizations. Levers were often used across a variety of settings, care providers, and clinical indications, though some levers addressed specific low-value care contexts. Fiscal policy levers or those influencing service provision were more restrictive, while clinician and patient behaviour levers and those aimed at popula-

tions or organizations were less restrictive. Evidence was identified for 40 levers, with 9 levers considered high impact (> 5% change to behaviour, utilization, or cost) or consistently supported (> 10 studies, the majority reporting desired effects). Conclusion : This inventory can support health systems in addressing low-value care, through the ability to compare policy levers and select those applicable to the particular context.

Prévention

Prevention

► **Advancing Equity in Preventive Care: Leveraging Hospital Admissions for Vulnerable Populations**

ALLAUDEEN, N., HUBERMAN, D. B. ET LE, E.
2025

American Journal of Public Health 115(12): 1997-2001.

<https://doi.org/10.2105/ajph.2025.308218>

To supplement traditional preventive care models, we leveraged hospital admission to address overdue vaccinations, cancer screening, and laboratory tests. A total of 28.7% of patients had at least one overdue preventive care item; 70.9% of these patients received at least one preventive care intervention during their hospitalization. Patients experiencing housing instability or with more than a year since their last primary care appointment were more likely to benefit. This intervention demonstrates hospitalization as an opportunity to address inequities in preventive care. (Am J Public Health. 2025;115(12): 1997–2001.

► **Democracy, Trust, and Political Orientation: Disentangling Mechanisms Shaping Individuals' Vaccine Attitudes**

ANTONINI, M., SINGH, R., MELEGARO, A., *et al.*
2026

Journal of Health Politics, Policy and Law 51(1): 45-82.

<https://doi.org/10.1215/03616878-12166725>

Context: In recent decades, many countries experienced a reduction in the quality and functioning of

democratic institutions and norms accompanied by rising social distrust and opposing political views. The decline in vaccine confidence might be linked to these trends. This study explores the political factors influencing individual attitudes toward vaccination across 22 upper-middle-income and high-income countries, examining the interaction between political orientation, trust in public health authorities, and levels of democracy. Methods: The authors used the VaxPref database, encompassing demographically representative data from 50,242 respondents collected between July 2022 and June 2023, to conduct an analysis on three levels: pooled sample, democracy groups, and country-specific analyses. Results: The authors found that higher democracy scores generally correlated with lower levels of vaccine skepticism. People in the political center and on the political right expressed more skepticism toward vaccines overall. However, trust in public health authorities emerged as the determinant that explains the largest variation in vaccine attitudes. Conclusions: These findings suggest a greater effectiveness of democratic systems in fostering vaccine confidence and the need to depoliticize vaccination efforts. Building and maintaining trust in scientific information and technical expertise is critical. Blunt measures like vaccination mandates may not sustain long-term confidence, particularly in democratic contexts. Effective interventions should prioritize comprehensive school-based education to promote preventive health behaviors coupled with targeted trust-enhancing communication strategies.

► **Éducation Thérapeutique du Patient dans les maladies rares : bilan des appels à projets DGOS 2019-2020 et perspectives d'amélioration**

BOUILLE, R., BALBOLIA, S., BARBET, A., *et al.*

2025

Santé Publique 37(3): 179-201.

<https://doi.org/10.3917/spub.255.0179>

Introduction : Avec deux appels à projets (AAP) en 2019 et 2020, la Direction générale de l'offre de soins (DGOS) a financé des programmes d'éducation thérapeutique du patient (ETP) dans les maladies rares, encourageant le développement de l'ETP à distance (e-ETP), l'implication des aidants et la collaboration inter-filière de santé maladies rares (FSMR). Méthode : Décrire l'impact des AAP sur le développement de l'ETP dans les maladies rares, en analysant les obstacles et les leviers rencontrés. Résultats et discussion : Parmi les 217 programmes d'ETP répertoriés, 63 % (n=137) ont répondu au questionnaire. 34 % des programmes sont concentrés en Île-de-France. Les programmes s'adressent à diverses classes d'âge, enfants (44 %), adolescents (63 %), adultes (64 %), personnes âgées (23 %). Les financements ont permis de créer 100 nouveaux programmes, d'en actualiser 22 existants et d'en déployer 13 dans de nouvelles régions. Parmi les nouveaux programmes, 83 incluaient des modalités innovantes (e-ETP et/ou aidants). 75 % des programmes s'adressent à la fois aux patients et à leurs aidants. Les parents sont les aidants majoritaires (56 %), suivis des conjoints (29 %), de la fratrie (28 %), et des autres aidants familiaux (30 %). 90 % des programmes incluent des ateliers en présentiel, 43 % sont mixtes (présentiel et à distance), et 10 % exclusivement à distance. La mutualisation entre FSMR reste limitée, seulement 5 collaborations déclarées. Conclusions : Les AAP ministériels 2019 et 2020 ont permis un développement significatif de l'e-ETP et une forte implication des aidants. Cependant, la mutualisation des programmes entre FSMR reste limitée. Des obstacles administratifs et de ressources sont identifiés, suggérant la nécessité d'améliorer l'accessibilité et la personnalisation de l'ETP.

► **Vaccination and Risk Aversion: Evidence From a Flu Vaccination Campaign**

GARROUSTE, C., JUET, A. ET SAMSON, A. L.

2026

Health Economics 35(1): 36-51.

<https://doi.org/10.1002/hec.70037>

ABSTRACT We examine the causal effect of a French flu vaccination campaign on vaccination behavior. Individuals aged 65 and over receive an invitation letter with a voucher for a free flu shot, while those who are not eligible have to cover the costs themselves. Using a Fuzzy Regression Discontinuity Design, we find that receiving the invitation letter with the voucher leads to a significant increase in the likelihood of getting vaccinated. This effect is driven by individuals who are risk-averse. As illustrated in our theoretical model, for them, the costs of influenza infection outweigh the costs of the vaccine's side effects.

► **Funding Health Promotion Activities to Reduce Avoidable Hospital Admissions in Frail Older Adults (HomeHealth): Further Challenges to the "Cost-Effective but Unaffordable" Paradox**

HUNTER, R. M., FROST, R. ET KALWAROWSKY, S.

2025

Applied Health Economics and Health Policy 23(6): 1099-1113.

<https://doi.org/10.1007/s40258-025-00987-4>

Health promotion initiatives are often promoted as being worth the investment given future cash-savings. This paper uses the findings of HomeHealth, a health promotion service for older adults with mild frailty, to examine how economic evaluation relates to local decision making in England.

► **General population preferences for health-related protective behaviors during infectious disease emergencies: a systematic review of conjoint-analysis studies**

LI, N., RAMBOD, B., DUKERS-MUIJRS, N., *et al.*

2026

Social Science & Medicine 388: 118721.

<https://doi.org/10.1016/j.socscimed.2025.118721>

Objective To primarily systematically review the evidence from conjoint analysis (CA) studies on general population preferences for health-related protective behavioral measures during infectious disease emergencies, to secondarily assess the role of social networks in shaping decisions and to synthesize quantitative data to inform behaviorally responsive epidemiological models. Methods PubMed and EMBASE were searched to identify relevant CA studies

published up to June 2025. In addition to study characteristics, the scope of protective measures of included studies were examined and categorized according to seven pre-defined groups; the relative importance of attributes in each study was ranked and compared across studies and the heterogeneity of preferences was explored. The ISPOR checklist was used to assess the quality of reporting of included studies. Results Of 2,523 articles identified, 16 studies were included. The quality of included studies was high with an average score of 24.7 out of 30 (range 18.5–28.5). Lockdown and restriction-related measures were most frequently perceived as important. A moderate level, targeted lockdown in a short period was preferred over severe or no restrictions. Face mask wearing and physical distancing were generally highly valued and preferred; for these measures, there was a clear preference for voluntary compliance over mandatory enforcement. Selective public spaces closures were preferred over broader shutdowns. Long-lasting, mandatory, and broadly applied quarantine was generally less preferred, while targeted quarantine was more acceptable. Substantial heterogeneity in preferences across populations was identified; age- and risk-based discrepancies in preferences were reported. Conclusion This review demonstrates the complexity of public preferences for protective measures and highlights the importance of aligning public health strategies with individual preferences by taking into account substantial heterogeneity. Incorporating these insights into policy and mathematical modelling frameworks would be helpful to enhance the acceptability and adherence of health-related protective measures in future pandemic preparedness.

► **Cost-Effectiveness of a Universal School-Based Mental Health Prevention Program: An Economic Modeling Study in a Limited Income Context**

NGUYEN, H. T., NGUYEN, A. Q., NGUYEN, N. T., *et al.*
2025

Applied Health Economics and Health Policy 23(6): 1085-1098.

<https://doi.org/10.1007/s40258-025-00982-9>

This study aims to evaluate the cost-effectiveness of a school-based mental health prevention program in a limited income context to inform investment decisions.

► **Améliorer la connaissance et la reconnaissance des interventions non médicamenteuses : implications pour la santé publique d'une étude participative et de consensus**

NINOT, G., DESCAMPS, E., ACHALID, G., *et al.*
2025

Santé Publique 37(3): 113-132.

<https://doi.org/10.3917/spub.pr2.0078>

Introduction : Devant l'absence de consensus sur la définition et l'évaluation des interventions non médicamenteuses (INM) malgré l'utilisation de la notion par l'OMS, la HAS, le ministère de la santé et le Centre européen de prévention et contrôle des maladies par exemple, une étude a co-construit un paradigme consensuel répondant aux standards de la recherche internationale dans le domaine de la santé. L'article présente ses intérêts et ses limites pour la santé publique. Méthode : L'étude a mobilisé durant deux ans toutes les parties prenantes, soit plus de 1 000 personnes. Des ateliers participatifs s'appuyant sur les recommandations internationales de la recherche en santé et l'expérience et des sessions de consensus ont été menés sous le pilotage d'un comité pluridisciplinaire et la logistique de la société savante Non-Pharmacological Intervention Society. Ils ont permis d'identifier les invariants descriptifs et évaluatifs spécifiques aux INM. Quatre phases se sont succédé, élaboration, amélioration, vote, consultation. Résultats : Le terme INM désigne des protocoles de prévention ou de soin ayant une dominante corporelle, nutritionnelle ou psychosociale, ciblés sur un problème de santé et personnalisés par un professionnel qualifié. Le cadre d'évaluation comporte 77 invariants, 14 éthiques et 63 méthodologiques. Ces derniers sont répartis en cinq types d'étude : mécanistique, observationnelle, prototypique, interventionnelle et d'implémentation. Le paradigme NPIS Model a reçu le soutien de 31 sociétés savantes et trois autorités de santé françaises. Conclusion : Le terme INM devrait être réservé aux protocoles de prévention et de soin décrits, explicables, efficaces, sûrs et implémentables. Le cadre consensuel d'évaluation co-construit devrait favoriser la transférabilité des INM de la recherche à la pratique, leur coordination pluriprofessionnelle, leur adaptation au contexte, leur amélioration continue, leur formation, et finalement leur reconnaissance. Ce paradigme scientifique renforce le rôle des professionnels de la santé publique dans le développement d'actions ciblées, efficaces, et possiblement financables au bénéfice des publics à risque ou malades.

Il ouvre la voie au développement d'un référentiel en accès libre de pratiques immatérielles de santé codifiables, partageables, traçables et améliorables

par la prise en compte des retours d'expérience. Ce paradigme ne couvre en aucun cas tous les domaines de la santé publique.

Psychiatry

Psychiatrie

► Incentivizing co-occurring disorder diagnoses through blended payments

BASLOCK, D., MANUEL, J. I. ET STANHOPE, V.
2026

Social Science & Medicine 389: 118849.
<https://doi.org/10.1016/j.socscimed.2025.118849>

Abstract: Background Treatments for mental health and substance use problems have historically been unintegrated, limiting co-occurring disorders treatment. Blending discrete payment models is one potential facilitator of integrated care. This study assesses the impact of one blended payment strategy on the diagnosis of co-occurring disorders in a community mental health system. Methods Electronic health record data for 19373 individuals, with 173889 observations from January 2017 through December 2019 was analyzed for this study. Multilevel growth modelling was used for data analysis. A binary dependent variable represented whether a service user held diagnoses of co-occurring disorders within a month. Fixed effects included time variables and a variable representing blended payment initiation as well as race, gender, age, and payor. Service user and agency variables were modeled as random effects. Findings Blended capitated and fee-for-service payments were found to increase the odds of service users receiving co-occurring diagnoses. People of color had lower odds of receiving a co-occurring diagnosis, although this effect did not hold in an analysis of rural agencies. Service users receiving care in unintegrated agencies had higher odds of receiving co-occurring diagnoses. Conclusion This study is one of the first to assess the impacts of a blended payment model on behavioral health access. Blended payment models can incentivize behavioral health providers and systems to identify complex diagnoses that may go unrecognized in routine care.

► The impact of PhD studies on mental health—a longitudinal population study

BERGVALL, S., FERNSTRÖM, C., RANEHILL, E., *et al.*
2025

Journal of Health Economics 104: 103070.
<https://doi.org/10.1016/j.jhealeco.2025.103070>

Recent self-reported and cross-sectional survey evidence documents high levels of mental health problems among PhD students. We study the relationship between PhD studies and mental health care utilization using Swedish administrative records of prescriptions for psychiatric medication for the full population of PhD students. We find that prior to starting their PhD studies, prospective students use psychiatric medication at a rate similar to a matched sample of individuals with a master's degree. However, following the start of their PhD studies, psychiatric medication use among PhD students increases substantially. This upward trend continues throughout the course of PhD studies, and by the fifth year medication use has increased by 40 percent compared to pre-PhD levels. After the fifth year, when most students in our sample graduate, the psychiatric medication use declines notably. Heterogeneity analyses indicate that the increase in medication use occurs broadly across different student subgroups and academic disciplines, with the exception of students in the medical and health sciences.

► Le vécu de l'électroconvulsivothérapie par les professionnels de santé

BOUAZIZ, L. ET ADRIEN, V.
2025

L'information psychiatrique Vol. 101(8): 617-626.
<https://doi.org/10.1684/ipe.2025.2932>

L'objectif de cette étude est d'explorer le vécu de l'électroconvulsivothérapie (ECT) par des soignants. Sept participants d'origines professionnelle et géo-

graphique variées ont été recrutés puis rencontrés entre novembre 2021 et mai 2022. Les analyses des entretiens ont révélé 4 méta-thèmes : 1) Malgré les représentations *a priori* que les soignants ont de l'ECT, ils font l'expérience d'une efficacité importante du traitement et d'une bonne tolérance par les patients. 2) Leurs appréhensions pour la réalisation du traitement s'apaisent généralement par l'expérience. 3) Leur posture empathique est un pilier pour la construction d'une relation de confiance, permettant le bon déroulement de l'ECT. 4) La question de la responsabilité reste une préoccupation importante. Cette étude contextualise la réalisation du traitement par ECT à partir du vécu des soignants qui le réalisent. Elle offre un angle de vue expérientiel des soignants, peu exploré à ce jour, par rapport à celui des patients ayant reçu ce traitement

► **2025 ESC Clinical Consensus Statement on mental health and cardiovascular disease: developed under the auspices of the ESC Clinical Practice Guidelines Committee: Developed by the task force on mental health and cardiovascular disease of the European Society of Cardiology (ESC) Endorsed by the European Federation of Psychologists' Associations AISBL (EFPA), the European Psychiatric Association (EPA), and the International Society of Behavioral Medicine (ISBM)**

BUENO, H., DEATON, C., FARRERO, M., ET AL
2025

European Heart Journal 46(41): 4156-4225.
<https://doi.org/10.1093/eurheartj/ehaf191>

This clinical consensus statement on mental health and cardiovascular disease highlights the multidirectional relationship between mental health, cardiovascular health and cardiovascular disease and its impact on cardiovascular risk and prognosis. Consensus statements from a multidisciplinary task force provide advice on assessment and management of mental health conditions in people at risk for and living with cardiovascular disease, as well as for persons with severe mental illness and other specific subgroups. Changes to practice are advocated to integrate mental health into person-centred care of patients with cardiovascular disease and more research to understand better how to improve assessment and management of mental and cardiovascular health together.

► **Mapping Mental Health Across US States: the Role of Economic and Social Support Policies**

DONNELLY, R. ET FARINA, M. P.
2025

The Milbank Quarterly 103(S1): 16-31.
<https://doi.org/10.1111/1468-0009.70015>

Policy Points This perspective argues that state economic and social support policies are key determinants of population mental health. Key policy successes of the past decade include state expansion of Medicaid eligibility, increase in minimum wage, and implementation of paid sick leave. Key policy priorities include the prioritization of evidence-based policies that improve economic security and the expansion of social support policies that are not tied to employment.

► **Optimal mental health belief formation with information avoidance: A decision-theoretic model**

KIM, D.
2025

Journal of Health Economics 104: 103084.
<https://doi.org/10.1016/j.jhealeco.2025.103084>

Mental health stigma hinders access to healthcare by distorting belief formation and decision-making. Stigmatized individuals often underestimate their risk of mental illness and avoid diagnostic information. This study develops a decision-theoretic model that formalizes how stigma reinforces identity-congruent actions, driving belief distortion and information avoidance. By integrating insights from information preference theory and identity utility, the model explains why individuals with strong stigma-driven identity concerns are prone to optimistic bias and resist diagnostic tests to protect their self-concept. The study contributes to the literature in three key ways. First, it conceptually extends economic theory by endogenizing belief distortion, identity-congruent action, and information avoidance within a unified decision-making structure. By introducing stigma as a formally modeled individual-specific parameter — previously underexplored in economics — the framework improves our ability to capture heterogeneity in health-related decision-making and strengthens the theoretical bridge between economic modeling and clinical mental health research. Second, it provides a theoretical framework linking clinical phenomena such as denial, delayed treatment-seeking, and treatment discontinuation within a formal

decision-theoretic model. Third, it offers a structured foundation for experimental and empirical research by demonstrating how stigma, a quantifiable construct, systematically influences decision-making through identity-driven actions and belief distortion.

► **Integrating Mental Health and Substance Use Treatment With Emergency and Primary Care: the Case of Opioid Use Disorder and Suicide**

KRAWCZYK, N. ET SAMPLES, H.
2025

The Milbank Quarterly 103(S1): 213-251.
<https://doi.org/10.1111/1468-0009.70028>

Policy Points There have been significant advancements in expanding care for opioid use disorder and suicide in general medical settings in the first quarter of the 21st century. Incessant barriers in the US health system continue to hinder progress in sufficiently scaling up evidence-based behavioral health interventions and getting them to those at highest risk. State policy-makers have multiple levers available to make significant improvements to address ongoing challenges and improve access to evidence-based behavioral health services in emergency and primary care settings.

► **COVID-19, economic downturn, and long-term trajectories of population mental health: evidence from two nationally representative British birth cohorts at the intersection of gender and socioeconomic position**

MORENO-AGOSTINO, D., PLOUBIDIS, G. B. ET DASMUNSHI, J.
2026

Social Science & Medicine 389: 118830.
<https://doi.org/10.1016/j.socscimed.2025.118830>

Background We examined long-term trajectories of mental (ill-)health in two British generations ('Baby boomers' and 'Generation X') across the life-course, including the COVID-19 lockdowns and the following cost-of-living increases. We analysed inequalities by generation, gender, socioeconomic position (SEP), and their intersections, and explored the relationship between inflation and mental (ill-)health post-lockdown. Methods and Findings We used data from the National Child Development Study (NCDS/1958, n=8,215) and the 1970 British Cohort Study (BCS/1970,

n=7,789), with repeated measures of psychological distress (Malaise Inventory) between ages 23-64.5 (NCDS/58) and 26-52.5 (BCS/70). We used multilevel growth curve models to study long-term trajectories, and negative binomial regression models to analyse associations with inflation/cost-of-living in the 2021-2023 period. Distress increased during the pandemic but declined post-lockdown (second quadratic spline: BNCDS/58=-0.12 [-0.17, -0.08], p<0.001; BBCS/70=-0.16 [-0.21, -0.11], p<0.001). Women and individuals from disadvantaged childhood SEPs started their trajectories with significantly (p<0.001) higher distress levels in both cohorts (women: BNCDS/58=0.72 [0.62, 0.82], BBCS/70=0.73 [0.62, 0.83]; manual-class background: BNCDS/58=0.24 [0.14, 0.35], BBCS/70=0.23 [0.12, 0.35]; rented housing: BNCDS/58=0.34 [0.22, 0.46], BBCS/70=0.30 [0.15, 0.45]). Inequalities were larger for women from disadvantaged SEPs born in 1958, indicating intersectional effects. None of these inequalities significantly reduced in the long term. Inflation/cost-of-living was significantly associated with distress, but effects did not vary by gender, concurrent SEP, or their intersection. Conclusions Despite post-pandemic improvements, persistent inequalities by gender and childhood SEP remain. Considering the high levels of socioeconomic adversity in the UK, action is needed to reduce these inequalities and prevent their transmission across generations.

► **L'intelligence artificielle en psychiatrie : promesses cliniques, reconfiguration ontologique et émergence d'un nouveau cadre épistémique**

MOUCHABAC, S. ET MALLARD, S.
2025

L'information psychiatrique Vol. 101(9): 685-691.
<https://doi.org/10.1684/ipe.2025.2948>

L'intelligence artificielle (IA) ouvre une nouvelle ère pour la psychiatrie, en introduisant des dispositifs innovants : télépsychiatrie, thérapies digitales, agents conversationnels et phénotypage numérique, systèmes d'aide à la décision, analyse de biomarqueurs et signaux faibles. Ces outils transforment la continuité des soins, facilitent l'accès et permettent d'anticiper les évolutions cliniques grâce à des données en temps réel. Ils inaugurent une mutation ontologique, en déplaçant la discipline d'une approche catégorielle vers des modèles relationnels et processuels, fondés sur des signatures numériques et des proxys comportementaux. Si des défis persistent (attrition, standards

méthodologiques, hétérogénéité de l'acceptabilité) l'IA constitue déjà un levier de personnalisation et d'empowerment inédit pour les patients. Elle favorise l'émergence de modèles hybrides de soin, articulant la richesse intersubjective et la puissance algorithmique. Elle ne remplace pas la psychiatrie, elle l'augmente annonçant une transformation profonde et durable de la discipline.

► **Review of Emergent Financing Models for Mental Health Crisis Systems**

PURTLE, J., MAURI, A. I. ET FREDERICK, D.
2025

Milbank Q 103(S1): 32-49.

<https://doi.org/10.1111/1468-0009.70014>

Policy Points The sources and adequacy of funding for crisis systems currently varies significantly among the US states and across services in the crisis continuum. Crisis services are funded by a wide range of sources, including 988 telecom fees and other state appropriations, community mental health services block grants and other federal funding sources, Medicaid, and commercial insurance. Priority areas for research related to financing crisis systems include evaluating the effects of 988 telecom fees, value-based payment models, and non-Medicaid payors.

► **Integrative models of psychopathology and psychotherapy: A PRISMA-based scoping review**

SAUR, R., FOUREL, E., DOS SANTOS, S., *et al.*
2025

L'Encéphale 51(6): 668-676.

<https://doi.org/10.1016/j.encep.2025.03.001>

INTRODUCTION: Since the 1970s there has been increasing interest in integrative approaches to psychopathology. Within this framework, numerous models have been developed. The aim of this manuscript is to inventory these models, provide a critical evaluation of them, and offer recommendations for their further development. **METHOD:** We conducted a scoping review based on PRISMA guidelines. The search strategy included keywords related to psychotherapy and/or psychopathology, one keyword related to models or conceptualizations, and one keyword associated with the integrative notion. The selected studies focused exclusively on integrative models of psychopathology and/or psychotherapy. The research was carried

out using PsycInfo, PubMed, and EMBASE databases. **RESULTS:** A total of 61 manuscripts were included in the systematic review. We identified a broad range of conceptual proposals, which can be categorized into three main types of models: 1) Models proposing a general framework for understanding psychopathology, 2) Models focusing on common factors in psychotherapy and 3) Models suggesting that a specific psychotherapy is inherently integrative. **CONCLUSIONS:** Many of these identified models face criticism for their lack of clear methodological development, limited empirical evidence, and/or restricted applicability to psychotherapeutic interventions. Future models should aim to address these limitations in order to advance the field.

► **Virginia's inpatient mental healthcare geography post SB260**

SCHWOERER, M. ET LESLIE, T. F.
2026

Health Policy OPEN 10: 10152.

<https://doi.org/10.1016/j.hpopen.2025.100152>

This study explores the impact of mental health policy reforms on geographic variations in inpatient psychiatric facility utilization and mental health outcomes in Virginia. Following the enactment of Senate Bill 260 (SB260), we observed significant changes in utilization patterns, particularly in regions with higher proportions of Medicaid-eligible populations. We identify nuanced factors influencing facility usage, including proximity to facilities and demographic characteristics, shedding light on the complex dynamics of mental health care access. Notably, our analysis indicates a notable increase in overall utilization of Virginia's state-operated mental hospitals post-SB260, suggesting a greater fulfillment of unmet needs for inpatient care. Moreover, our research underscores the necessity to reconsider IMD exclusion laws, emphasizing the potential benefits of policy changes for underserved populations. This research contributes to mental health policy discussions by offering evidence-based considerations for future reforms aimed at improving access and equity in mental health care delivery in Virginia.

► **Intelligence artificielle et psychiatrie : inquiétude et quels enjeux ?**

SHADILI, G. ET FAVRÉ, P.
2025

L'information psychiatrique 101(9): 715-720.

<https://doi.org/10.1684/ipe.2025.2952>

L'IA est utilisée en médecine somatique et psychiatrique où elle fait preuve d'une efficacité notable, bien que perfectible, pour établir un diagnostic ou certaines orientations thérapeutiques. L'IA, déjà performante en psychiatrie pour le diagnostic et la prévention, suscite de grands espoirs mais fait également naître des craintes au plan de l'éthique. Entre médecine de précision et approche de terrain, son intégration reste inégale. L'exemple allemand (DiGA) montre un usage encadré et remboursé, contrastant avec la France, encore sans psychothérapie numérique validée. L'IA en psychiatrie pourrait favoriser un accès élargi aux soins, un dépistage précoce et un soutien continu, mais fait courir le risque de perte du lien humain, d'illusions relationnelles et d'inadaptation aux relations réelles. Son usage exige vigilance critique, encadrement éthique et prise en compte de la complexité clinique.

► **Adverse childhood experiences partially mediate sexual minority disparities in depression, anxiety, and suicidality in a population-based study**

SMART, B. D., PACHANKIS, J. E. ET BRÄNSTRÖM, R.
2026

Social Science & Medicine 389: 118839.

<https://doi.org/10.1016/j.socscimed.2025.118839>

Sexual minority individuals experience persistently elevated risks of internalizing psychopathology and suicidality, to which increased exposure to adverse childhood experiences (ACEs; i.e., negative life experiences and circumstances before age 18) might contribute. In a population-based nationally representative sample, this study investigated sexual orientation identity differences in ACEs and whether these differences statistically mediated sexual orientation disparities in depression, anxiety, and suicidality. We also explored gender non-conformity as a potential contributor to sexual orientation differences in ACEs. A pre-registered, cross-sectional analysis was conducted with 19,421 participants ages ≥ 16 randomly sampled from Sweden's population registry with questionnaire-based exposures and outcomes. Compared to heterosexual participants, all sexual minority subgroups were more likely to experience ≥ 1 ACE: bisexual women (aOR = 2.96, 95% CI [2.23, 3.83]), lesbian women (aOR = 2.19, 95% CI [1.32, 3.63], gay men (adjusted odds ratio [aOR] = 1.97, 95% confidence interval [CI] [1.38, 2.81]), and bisexual men (aOR = 1.60, 95% CI [1.18, 2.17]). All sex-

ual minority subgroups experienced higher odds of bullying, domestic violence, adverse neighborhood experiences, and physical neglect. ACEs statistically mediated associations between sexual minority identity and depression, anxiety, suicidal ideation, and suicide attempt; indirect effects were significant for all sexual minority subgroups (aORs = 1.11–1.34), explaining 13–41% of increased risk, across groups and outcomes. Gender non-conformity partially statistically accounted (10–15% decrease in regression coefficients) for bullying and emotional abuse disparities. We conclude that disproportionate ACE exposure may partially explain elevated mental health problems among sexual minority individuals, especially bisexual women.

► **The same, but different: Understanding responsibility attributions for depression with a cross-national survey in the United States and Germany**

WAGNER, A., REIFEGERSTE, D. ET SCHERR, S.

2025

Health Policy 162: 105445.

<https://doi.org/10.1016/j.healthpol.2025.105445>

Understanding how the population attributes responsibility for depression is crucial for shaping the treatment of depressed individuals in society and influencing support for health-related policies. International findings suggest that responsibility attributions generally differ between countries and cultures. However, it is unknown whether they also differ between different healthcare systems within individualistic cultures. To address this research gap, we compared different responsibility attributions for depression (individual, genetic, social) in the United States (individual-based healthcare system) and Germany (solidarity-based healthcare system) in a cross-sectional online survey with 2,168 participants. Additionally, we examined factors associated with these attributions in both countries, including the use of health information sources such as alternative and social media, since media use – and the media frames conveyed through it – is linked to responsibility attributions. Results show that social context-attributions were most prevalent in both countries, but significantly more pronounced in Germany. In contrast, individual and genetic responsibility attributions were higher in the U.S. In both samples, the use of alternative media for health information-seeking was positively associated with individual attributions, while depression knowledge was linked to greater social and genetic attributions. Healthism attitudes

were positively related to all three types of responsibility attributions.

► **Estimating Medicaid Reimbursement For Psychological Services**

ZHU, J. M., HUNTINGTON, A., MITCHELL, E., *et al.*
2025

Health Affairs 44(12): 1530-1536.

<https://doi.org/10.1377/hlthaff.2025.00563>

Medicaid reimburses, on average, 74.0 percent of Medicare rates for psychological services, with nearly all states paying less than Medicare. Most states raised Medicaid reimbursement rates by 25–33 percent for three common psychotherapy and psychological testing services between 2019–21 and 2024.

► **Reported Strategies by Medicaid Managed Care Organizations to Improve Access to Behavioral Health Services**

ZHU, J. M., ROWLAND, R., SUNESON, I., *et al.*
2025

Milbank Q 103(S1): 297-318.

<https://doi.org/10.1111/1468-0009.70009>

Policy Points Despite the growing role of managed care organizations (MCOs) in financing and delivering behavioral health services in Medicaid, little is known about MCO strategies to overcome critical access barriers and the factors influencing these strategies. Through semistructured interviews of 27 administrators and executives across 19 local, regional, and national Medicaid MCOs, we describe a number of reported approaches to enhance behavioral health access: 1) contracting with core groups of Medicaid-focused behavioral health providers to provide a substantial share of care, and 2) targeted strategies to enhance the existing workforce through outreach, training, and workforce support programs; rate enhancements; telehealth and mobile unit care models; and high-touch case management. Findings highlight MCO perspectives on barriers and facilitators of access to behavioral health care, as well potential strategies that hold promise for other MCOs. Future research should evaluate the outcomes associated with these strategies and identify best practices that can be adapted across MCOs. **CONTEXT:** Behavioral health access gaps are well documented in Medicaid, in which managed care now covers most enrollees, and for which there are typically fewer options for going out-of-network

for care. Despite the growing role of managed care organizations (MCOs) in financing and delivering behavioral health services, little is known about MCO levers that can improve access to care. **METHODS:** We interviewed 27 administrators and executives across 19 Medicaid MCO carriers with local, regional, or national operating presence to understand strategies to address behavioral health access barriers and the factors influencing these strategies. To achieve maximum heterogeneity, we employed iterative purposive sampling using a sampling matrix of plan and state characteristics. One-hour interviews were recorded, professionally transcribed, and analyzed using a coding scheme that was developed iteratively. Codes were bundled into major themes after iterative discussions, with analysis conducted at the MCO level. **FINDINGS:** MCOs perceived acute access challenges for children and adolescents, rural geographies, and crisis and transitional services. To address these challenges, MCOs reported contracting with core groups of Medicaid-focused behavioral health providers, supplemented with targeted strategies to enhance the existing workforce. These strategies focused on enhancing provider retention and capacity through outreach, training, and workforce support programs; rate enhancements; telehealth and mobile unit care models; and high-touch case management to align members to appropriate providers or service levels. Strategies were influenced by state policy contexts, including by regional financing and organization of behavioral health services, rate setting procedures, and administrative and regulatory requirements. **CONCLUSIONS:** As state Medicaid programs increasingly grapple with behavioral health access gaps, understanding MCO approaches and common challenges may help policymakers better align resources, incentives, and regulations centered on improving existing gaps in accessing behavioral health care. Future research should evaluate the outcomes associated with MCO perceptions and accompanying strategies and identify best practices that can be adapted across MCOs.

Sociology of Health**► Le service de santé universitaire au prisme du genre : une étude de la portée**AZADI, B. ET KIVITS, J.
2025**Santé Publique 37(3): 203-216.**
<https://doi.org/10.3917/spub.255.0203>

Cette étude explore l'accès des étudiant.e.s aux services de santé universitaires à travers une analyse de la portée. Elle vise trois objectifs principaux : identifier les facteurs favorisant ou freinant le recours aux services de santé offerts par les universités, repérer l'intégration du genre dans les prises en charge des étudiant.e.s, et identifier les angles morts dans la recherche sur ce sujet.

► Être ou ne plus être les « petites mains » du chirurgien. L'impossible construction identitaire des infirmières de bloc opératoireEL HAÏK-WAGNER, N.
2025**Travail et emploi n° 176(2): 47-74.**

Le segment des infirmières de bloc opératoire (Ibode) dispose d'un moindre niveau de prestige et d'une plus faible attractivité que les infirmières anesthésistes. Ces professionnelles évoquent néanmoins leur travail en des termes passionnés et vocationnels. À l'appui d'un terrain ethnographique dans les blocs de chirurgie viscérale (adulte et pédiatrique) de deux centres hospitaliers universitaires (CHU) franciliens, cet article interroge ce hiatus entre valorisation interne et externe de l'activité, en se concentrant sur les missions exercées par les Ibode au cours des interventions chirurgicales et en réinscrivant ces dynamiques dans la rationalisation croissante de l'activité opératoire. Nous montrons que si les Ibode trouvent des espaces d'engagement actif dans leur travail et tirent des profits symboliques de la proximité aux praticiens, leur activité reste prise en étau par une double emprise chirurgicale et gestionnaire, qui contribue à son hétéronomie et perpétue leur position dominée dans l'ordre hospitalier.

► How do community assets support health in a rural community? An ethnographic case studyHAYES, J., EDWARDS-SMITH, L., BYNG, R., *et al.*
2025**Health & Place 96: 103569.**
<https://doi.org/10.1016/j.healthplace.2025.103569>

Community assets (including voluntary, community, social enterprise and grassroots initiatives) have the potential to help address health inequalities. There is a growing understanding of the importance of putting communities at the heart of public health to improve population health. Understanding the mechanisms by which grassroots activities support health and wellbeing is important for making commissioning decisions, for community confidence and for the purposes of evaluation. This study takes an ethnographic case study approach to explore one rural community in the south-west of England. We observed activities and interactions, had informal conversations with residents and community leaders and conducted focus groups. Focus groups were recorded, and transcripts and field notes were analysed thematically. Findings were mapped to South and colleagues' family of community-centred approaches. We explore to what extent this framework applies to grassroots activities in our case study site and consider how outcomes from these community assets (places, activities and people) may link to the evidence base behind this framework. We discuss the mechanisms by which these approaches support health and wellbeing, as well as the factors that may constrain their development. We suggest that, through linking to the evidence base, there is a case for investing in the transformational health-generating work of grassroots organisations.

► Favoriser l'engagement des bénéficiaires dans un programme sport-santé accessible sur prescription médicale : perspectives phénoménologiques et microsociologiquesLEFÈVRE, L., ORIVAL, T., KNOBÉ, S., *et al.*
2025**Santé Publique 37(3): 43-48.**
<https://doi.org/10.3917/spub.255.0043>

Introduction : En France, les politiques nationales de promotion de la santé par l'activité physique se traduisent localement par des dispositifs accessibles sur prescription médicale. Cependant, ces initiatives négligent souvent les facteurs sociaux influençant la participation. **Méthode :** L'enquête s'appuie sur une approche qualitative à visée phénoménologique, combinant observations de terrain et entretiens menés auprès des bénéficiaires du programme. L'analyse explore leur engagement à travers le prisme des appuis corporels, relationnels, matériels et spatiaux qu'ils perçoivent et mobilisent dans leur expérience des séances « Mulhouse Sport Santé ». **Résultats :** L'analyse met en évidence que l'engagement repose sur : des appuis corporels (perception des progrès physiques, gestion de l'effort) ; des appuis relationnels (soutien des enseignants en activité physique adaptée (APA), dynamique de groupe) ; des appuis matériels (usage routinisé du matériel, structuration des séances) ; et des appuis spatiaux (environnement sécurisant et prévisible). L'engagement ne repose pas uniquement sur une intention, mais sur une pluralité d'appuis favorisant ou freinant la participation. L'enseignant en APA joue un rôle clé en adaptant les séances et en accompagnant les bénéficiaires dans un processus de réappropriation corporelle. **Discussion :** Cette approche phénoménologique et microsociologique permet d'enrichir la compréhension des pratiques de promotion de la santé par l'activité physique. Elle met en lumière l'importance des dimensions corporelles, relationnelles et matérielles de l'engagement, et invite à repenser l'aménagement des espaces et les modalités pédagogiques pour les rendre véritablement capacitants.

► **A decade of discourse: Exploring sentiments and trends around immigration on social media from 2014 to 2024**

NGUYEN, T. T., MULLAPUTI, P. S. P., YUE, X., *et al.*
2026

Social Science & Medicine 388: 118715.
<https://doi.org/10.1016/j.socscimed.2025.118715>

Introduction Social media discussions contribute to the evolving public perception of refugees and immigrants. However, prior research often relied on a single platform and short-term analyses, offering a fragmented view of a highly dynamic phenomenon. **Objective** Examine trends in public narratives surrounding refugees and immigrants, including the evolution of sentiment and user engagement on Twitter, Facebook, and

Bluesky. **Methods** We analyzed 6.3 million U.S.-based English-language posts from Twitter (2014–2023), Facebook (2014–2024), and Bluesky (2023–2024), using platform APIs. Posts containing one or more of 129 immigration-related keywords were grouped into 76 categories. Sentiment was classified using a supervised Support Vector Machine model, and engagement was aggregated at the keyword level. Twitter geodata enabled state-level sentiment mapping. **Results** Peaks in volume and negativity aligned with major events, including the 2014 Syrian refugee crisis, the 2017 travel ban, and the 2018 family separation policy. From 2014 to 2019, negative sentiment increased on both Twitter and Facebook, then became more neutral in subsequent years. Bluesky began with predominantly neutral discourse in 2023 but grew more negative after its public launch. Refugee-related discourse was consistently less negative than immigrant-related discourse across all platforms, while enforcement-related and exclusionary rhetoric keywords emerged as the most negatively evaluated. Twitter geodata revealed widespread negativity across states, although refugee discourse remained more moderate or neutral than immigrant discourse overall. **Conclusion** Migration discourse is shaped by political events, emotional framing, and platform-specific dynamics, underscoring the need for cross-platform analyses to understand evolving digital narratives.

► **La déstandardisation des parcours de psychiatres salariés. Logiques d'adaptation dans une organisation sous contraintes**

ROBICQUET, P.
2025

L'Année sociologique 75(1): 69-96.
<https://doi.org/10.3917/anso.251.0069>

Depuis la fin des années 1990, le groupe des psychiatres se distingue par la féminisation et le vieillissement de sa population, par la relégation des savoirs théoriques à un plan plus secondaire, et par le souhait des nouvelles générations d'établir une séparation plus stricte entre leurs identités sociale et professionnelle. En dépit d'un taux toujours très important de salarisation (49 %), ces évolutions se traduisent notamment par une plus forte mobilité entre les établissements, par une demande de flexibilité au quotidien et par une hausse du recours au statut d'intérimaire. À partir de matériaux qualitatifs, cet article interroge le lien entre l'évolution des parcours des psychiatres salariés, moins

prévisibles que par le passé, et celle des conditions de travail au sein des hôpitaux de psychiatrie publique sectorisée. Derrière l'apparence éclatée des parcours, nous verrons des formes de permanence et d'adaptation de la part d'un groupe professionnel historiquement dominant, afin de préserver ses intérêts dans une organisation fragilisée et sous-contrainte.

► **Une crise sanitaire révélatrice d'une crise plus profonde au sein de la profession. Le cas des sages-femmes hospitalières en Île-de-France pendant la pandémie de Covid-19**

SCHANTZ, C., RODINO, I., YAHIAENE, L., *et al.*
2025

Santé Publique 37(4): 235-246.
<https://doi.org/10.3917/spub.254.0235>

Introduction : La crise sanitaire provoquée par la pandémie de Covid-19 (2020-2021) a contraint les hôpitaux à se réorganiser et les pratiques des professionnel·les de santé ont rapidement été bouleversées. Les maternités, et notamment les sages-femmes y travaillant, n'ont pas été épargnées par ces changements. But de l'étude : La recherche MATER-Covid19 a analysé l'effet de cette crise sur les expériences et vécus de sages-femmes qui ont accompagné les femmes ayant accouché depuis le début de la pandémie. L'objectif était de visibiliser l'impact de la pandémie sur leurs pratiques médicales, mais aussi leur vie quotidienne dans la sphère familiale et domestique. Pour cela, dans le cadre d'une recherche qualitative, nous avons mené 17 entretiens semi-directifs auprès de sages-femmes hospitalières en Île-de-France. Résultats : Les vécus des sages-femmes ont été caractérisés par une polarisation des ressentis avec, pour certaines, une grande « excitation » due à une situation sanitaire et sociale inédite, quand, par contraste, le quotidien des autres a été fortement marqué par la « peur ». La crise sanitaire a mis à mal le bien-être mental de plusieurs d'entre elles et a pu être révélatrice d'un mal-être plus général. La réémergence des polémiques sur les violences obstétricales, concomitante de cette crise, a renforcé le malaise d'une partie des soignantes et mis sur le devant de la scène une crise plus structurelle en France. Conclusions : Les vécus des sages-femmes pendant la pandémie ont été contrastés. La polémique sur les violences obstétricales a été ravivée par la crise sanitaire qui a été révélatrice de la crise actuelle de la profession.

► **Beyond Preferences: Rethinking Shared Decision-Making Through the Lens of Care**

TURRINI, M., VALENTI, R., LADEGAARD KNOX, J. B., *et al.*

2026

Social Science & Medicine 390: 118801.

<https://doi.org/10.1016/j.socscimed.2025.118801>

Efforts to involve patients in medical decision-making have led to the development of various models for structuring clinical encounters. Among them, Shared Decision-Making (SDM) is now a cornerstone of contemporary healthcare, based on the ethical imperative to involve patients through the articulation of preferences. However, in practice, SDM often relies on a rationalist model of deliberation that prioritizes autonomy, clarity, and informed choice—often overlooking the relational, affective, and embodied dynamics of care. Drawing on ethnographic fieldwork in France, Spain, and Denmark with patients undergoing long-term anticoagulant therapy following unprovoked venous thromboembolism (VTE), this article examines the contexts in which decisions are made, as well as patients' attitudes toward those decisions and their treatment. We argue that “preferences”—the conceptual hinge of SDM—are not stable expressions of autonomous will, but rather fragile, contingent, and emergent responses. Especially as understood and operationalized by practitioners, preferences often obscure other forms through which patient agency is exercised, both within and beyond the clinical consultation. Engaging Annemarie Mol's “logic of care”, we show how patient agency unfolds not as a rational choice between predefined options, but as an ongoing, situated negotiation of treatment that extends beyond the consultation. Furthermore, focusing on care, rather than choice, allows for a medical approach attentive to the patient's needs, demands, and hesitations—not solely to their stable preferences regarding treatment duration. These findings call for broadening participation beyond preference articulation, toward more responsive and context-sensitive forms of engagement.

Primary Healthcare

► **A composite and synthetic index of potentially avoidable hospitalization in adults to assess primary care quality: an application across Italian geopolitical areas**

ALIZADEH, A. H., CUOMO, M., BURGIO, A., *et al.*
2026

Health Policy 165: 105528.

<https://doi.org/10.1016/j.healthpol.2025.105528>

Background Avoidable hospitalizations for Ambulatory Care Sensitive Conditions (ACSC) are key proxy indicators of Primary Care (PC) services quality. Challenges in Italy's National Health Service, worsened by COVID-19, have spurred outpatient care reforms to ultimately reduce avoidable hospitalizations. Objective To provide a synthetic, composite and cross-national index of avoidable hospitalizations in adults, for evaluating PC services performance. Methods Nine avoidable hospitalization indicators for 2017-2019 and 2020-2022 were calculated from discharge data of Italian hospitals. Their standardized z-scores, grouped into five nosological areas, were equally weighted to ensure balanced representation. A final synthetic index for each area was classified into one of five Jenks clusters. Results The national hospitalization rate decreased from 148.17 per 1,000 residents in 2017-2019 to 125.98 in 2020-2022. Before COVID-19, the "low" clusters were 11, whereas the "high" clusters were 14. In 2020-2022, the "low" and "high" clusters changed to 13 and 10, showing a mild improvement. The "medium-low" and "medium-high" clusters reported significant changes, from 29 to 39 and from 29 to 20, respectively. The "medium" clusters have remained essentially unchanged (from 36 to 37). Conclusions The index distribution offers three main insights: consistently low values suggest efficient PC services; high values may indicate weak strategies or ineffective PC policies; heterogeneous distribution shows fragmented policies, implying better integration and evaluation. Despite potential biases involving patient behaviors and healthcare system factors, the synthetic index offers an evaluation tool for PC performance, reducing access inequalities, and guiding targeted improvements.

► **Integrating Primary Care and Public Health: Promising Pathways to Building Infrastructure and Delivering Services**

ANDERSON, K. M., BORRELL, L. N. ET THORPE, L.
2025

American Journal of Public Health 115(12): 1988-1991.

<https://doi.org/10.2105/ajph.2025.308297>

► **Impact of quality clusters on antibiotic prescribing patterns. A difference-in-differences study from Danish general practice**

BJØRNSKOV PEDERSEN, L., BUNDEGAARD, M.,
KLAUSEN FREDSLUND, E., *et al.*
2026

Health Policy 163: 105493.

<https://doi.org/10.1016/j.healthpol.2025.105493>

Globally, a more rational use of antibiotics is needed to face the threat of antimicrobial resistance. In 2018, quality clusters were introduced in Danish general practice as a new quality improvement initiative. In the clusters, general practitioners engage in self-selected quality improvement topics, such as antibiotics prescribing. This study investigates whether engaging with antibiotics as a topic in quality clusters improves antibiotics prescribing, and whether choice and number of quality improvement strategies matter for behaviour change. We link register data on redeemed antibiotics prescriptions from Danish general practice from 2015–2020 with survey data from 2020 on whether, when, and how practices in clusters engaged with antibiotics as a quality improvement topic. We use a difference-in-differences approach including general practice fixed effects and practice-averaged time-varying patient population characteristics in linear regressions models. We find that practices engaged with antibiotics as a quality improvement topic increase their proportion of narrow spectrum antibiotics prescriptions compared to other practices, while there is no difference in changes in the total number of prescribed antibiotics. Neither the choice nor the number of surveyed quality improvement strategies seem to influence the behavioural outcomes. In conclusion, engaging in antibiotics in quality clusters to some extent improved antibiotic prescribing.

► **Patients as Boundary Subjects in Home Care: How Patients Coordinate (Inter-) Professional Work**

DIEL, M., WEBER, C. E., MÜLLER, C., *et al.*
2026

Social Science & Medicine 390: 118852.
<https://doi.org/10.1016/j.socscimed.2025.118852>

ABSTRACT Home care typically requires healthcare professionals to coordinate their interdependent work. As existing research has shown, though, for professionals, coordination can be challenging for several reasons, such as time constraints, professionals' spatial separation, and information and communication systems that are not integrated. Our qualitative study investigated eight best-practice cases of home care in Germany and found early on that in these cases patients, as boundary subjects, actively coordinated (inter-)professional work. We therefore explored how patients coordinated home care, including cases where relatives acted as patients' spokespersons. We inductively analyzed 29 interviews, 9 non-participatory observations, and 59 informal conversations. Our findings reveal two distinct coordination approaches: (1) coordination by continuous synchronization, in which patients or relatives continuously direct, integrate, and monitor the work of healthcare professionals, and (2) coordination by initial configuration, in which patients or relatives set clear objectives and promote interprofessional connections at the onset of the collaboration. While the three areas of coordination—professionals' work execution, information and professionals' information exchange, and scheduling of professionals' work—are the same in both approaches, the efforts applied to achieve coordination are distinct. We contribute to the understanding of coordination of (inter-)professional work in home care by unpacking the involvement of patients and relatives in coordination work. Our research may inform the development of programs and policies to improve home care, either by empowering patients and their relatives or by establishing mechanisms and involve other actors to manage coordination when patient or relative involvement is limited or not feasible.

► **Judicious resource managers or administrative intermediaries: A systematic review of family physician perspectives on the administrative process of referring patients to other clinicians in high income countries**

ELMA, A., SCHOLE, A. K., SINGER, A., *et al.*
2026

Health Policy 165: 105527.
<https://doi.org/10.1016/j.healthpol.2025.105527>

ABSTRACT Background Family physicians play a key role in coordinating and managing patient referrals to specialist care. While central to patient care, the referral process has been described as a disproportionately time-consuming and administratively demanding process, contributing to family physician burnout, stress, and attrition. Given the growing recognition of how administrative burden contributes to burnout, stress, and physician attrition from family medicine, it is crucial to examine the nature and impacts of this workload. Objective To describe the range of perspectives and experiences of family physicians on the referral process. Methods We conducted a systematic review of mixed-methods studies using a convergent integrative synthesis approach. Eligible studies were peer-reviewed, conducted in OECD countries, and published between 2012-2025. Quantitative data were transformed into portable narrative statements to enable integrated analysis with qualitative data. Constant comparative analysis was applied across different countries and study outcomes. Results Thirty-one studies were included, conducted in 13 high-income countries. The referral process was characterized as requiring clinical, technological, and social competence, involving decisions about whether and how to refer, and constructing and following up on referrals. This work was further complicated by strained and fragmented healthcare systems, positioning family physicians in the role of bridging system gaps for patients. These challenges resulted in additional paperwork, unnecessary referrals, delays, and rejections, which exacerbated system inefficiencies as opposed to improving resource use. Ultimately, this contributed to physician burnout, reduced professional autonomy, and job dissatisfaction. Conclusions Ameliorating referral-related burden will require system-level reform and examination of intra-professional power structures.

► **How to increase the supply of primary care services in underserved areas? The impact of the location of multidisciplinary primary care teams on the density of physiotherapists in France**

GALHARRET, Y., VIDEAU, Y. ET MOUSQUÈS, J.
2025

Annals of Economics and Statistics(158): 125-158.
<https://doi.org/10.2307/48845131>

[France faces both a huge shortage of General Practitioners (GPs) and a geographical imbalance in the distribution of primary healthcare professionals. This study analyses whether establishing Multidisciplinary Primary Care Teams (MPCTs) in areas with limited access to primary care increases the density of physiotherapists (PTs) by attracting and retaining PTs. Our contribution expands the literature on the determinants of primary health care providers' geographical distribution. Utilising a panel data from 2012 to 2022 with a staggered difference-in-differences (DiD) estimation strategy, we compare the evolution of self-employed PTs density in HLAs that experienced the opening of MPCTs to similar areas without MPCTs. The findings indicate that the establishment of MPCTs in the most underserved HLAs, eligible to financial incentives targeting the attraction and retention of PTs, results in an increase in PTs density by more than five PTs per 100,000 inhabitants. This finding suggests that, in primary care, the promotion of multidisciplinary team practices like French MPCTs, in combination with financial incentives to attract and retain health professionals, improves healthcare workers density in areas with limited access to primary care services.]

► **Sortir de la médecine générale libérale : les effets croisés de la socialisation professionnelle, de classe et de genre**

GARCIA, S., GELLY, M. ET HAMELIN, C.
2025

Travail, genre et sociétés n° 54(2): 99-116.
<https://doi.org/10.3917/tgs.054.0099>

Si l'entrée dans la profession de médecin généraliste et ses modalités d'exercice ont fait l'objet d'enquêtes sociologiques nombreuses, les formes de sortie du métier sont peu explorées. Cet article les éclaire par l'analyse de la socialisation professionnelle et de ses inflexions. Notre enquête par entretiens, dans des territoires ruraux et péri-urbains populaires, avec 65 médecins généralistes ayant quitté ou aménagé l'exercice

libéral révèle les coûts genrés de la non-conformité à un modèle professionnel de disponibilité ajusté à un état antérieur (masculin) de la profession. Nous montrons que les sorties ou l'aménagement de l'exercice libéral répondent à des crises dispositionnelles révélant le désajustement des médecins au modèle professionnel de la disponibilité permanente, et qu'elles sont déterminées par la socialisation primaire, de classe et de genre. Enfin, nous montrons comment le recul des services publics favorise les sorties de la médecine générale libérale.

► **How to scale up and implement integrated care?**

GINNEKEN, D. E. V., STRUCKMANN, D. V., RIJKEN, D. M., *et al.*

2025

Health Policy 160: 105514.
<https://doi.org/10.1016/j.healthpol.2025.105514>

► **Nurse-led models of care and their potential to improve primary healthcare for refugees in Germany: A qualitative multiple-case study**

GOLD, A. W., PERPLIES, C. ET BOZORGMEHR, K.
2026

Health Policy 165: 105529.
<https://doi.org/10.1016/j.healthpol.2025.105529>

Background Fragmented health systems can lead to over-, under-, or misuse of services. Specific challenges arise for newly arrived population groups, such as refugees, who encounter barriers to health services. These include legal restrictions and language discordance with service providers, that further exacerbate these issues. Although nurses can play an important role in improving the response of the health system, little is known about their scope of practice and their role in caring for refugees in primary healthcare contexts. Objective To investigate key characteristics of three nurse-led models of care for refugees in Germany, the roles and responsibilities of nurses and to describe their potential to improve coordination and continuity. Methods A qualitative, multiple-case study was conducted using a purposeful sampling strategy. Data collection included semi-structured interviews with three programme managers and five nurses from three operational nurse-led models of care in Germany, a social network questionnaire and a review of documents. Data analysis comprised developing logic models and

using qualitative content and social network analysis methods. Results Examined models involve nurses by allowing for independent management of tasks such as observation, counselling, and care coordination, providing support to patients and linking them to other healthcare services. In the absence of specific training programmes, nurses rely on on-the-job learning. Conclusions Nurse-led models of care can effectively improve healthcare for refugees. Policymakers should recognise and advance nursing practice through legislative measures and sustainable funding models. In order to prepare nurses for working in these settings, nursing curricula should incorporate refugee-specific aspects.

► **New ways of working in Irish general practice: Policy implications for medical workforce planning.**

HUMPHRIES, N., HANLON, H. R., O'CALLAGHAN, M., *et al.*

2026

Health Policy 164: 105505.

<https://doi.org/10.1016/j.healthpol.2025.105505>

Background General practice in Ireland has changed significantly with increased participation of women in the workforce; a move from single-handed to group practices and an increased prioritisation of work life balance. Objective This paper explores how GP ways of working have changed. By presenting qualitative data from GPs in Ireland, we present GP perspectives on part and full time working and highlight the need to capture new ways of working by GPs (via research and routine data), and use it to inform GP workforce planning. Method To provide an in-depth exploration of GP working life, the study employed a qualitative method of remote ethnography which involved recruiting 20 GPs in Ireland, conducting two online interviews with each GP and conducting an eight-week discussion via Threema (instant messaging application). Data collection was conducted from October 2024 to July 2025. Research ethics permission was granted by the institutional ethics committee. Results GPs discussed heavy workloads and high work intensity, long working hours and a heavy burden of administrative work. They explained how reduced working hours and job crafting were used to reduce the intensity of their working week, achieve work-life balance and reduce their stress levels. Conclusion Participant GPs reported reducing the number of clinical sessions worked in order to protect their wellbeing and achieve work-life balance. These

new ways of working must be evaluated using research and routine data collection to capture the work-as-done by GPs (rather than the work-as-imagined) in order to inform policy and GP workforce planning.

► **The impact of vertical integration on health care delivery and costs: Evidence from physician–pharmacy integration**

KAKANI, P.

2025

Journal of Health Economics 104: 103085.

<https://doi.org/10.1016/j.jhealeco.2025.103085>

Vertical integration among health care providers is an increasingly common feature of U.S. health care. This study investigates the impact of vertical integration in the context of oncology practices launching in-house pharmacies dispensing high-cost oral cancer treatments using a stacked event study design. I find physician–pharmacy integration lowers point-of-sale drug prices paid by plans due to 1.0% lower prices at in-house pharmacies. I also find physician–pharmacy integration increases the number of patients filling new prescriptions by 6.2% and reduces time-to-fill for new prescriptions requiring prior authorization. These effects may arise because in-house pharmacies individually have limited bargaining power and because vertical integration decreases coordination costs, reflected by faster prior authorization.

► **Nursing shortages and patient outcomes**

KELLY, E., PROPPER, C. ET ZARANKO, B.

2026

Journal of Health Economics 105: 103082.

<https://doi.org/10.1016/j.jhealeco.2025.103082>

This paper examines the effect of nurse shortages on healthcare production. Employing novel high-frequency data, we examine what effect the absence of nursing staff has on inpatient mortality and other outcomes associated with nursing care. We find significant adverse mortality impacts of shortages of nurses with degree-level qualifications: for the average ward, the absence of a nurse with university degree-equivalent level training increases the odds of a patient death by approximately 10%, while there is no effect of shortages of less qualified nursing assistants. For qualified nurses, there are returns to firm (hospital) specific human capital: increasing the average firm-specific experience among degree qualified nurses by one

year is associated with an 8% reduction in the odds of a patient death, the equivalent to adding three-quarters of an extra qualified nurse to the ward. Adverse mortality impacts of shortages are particularly concentrated among patients of relatively low, rather than high, clinical severity. The largest impacts are for those diagnosed with sepsis, a condition where early detection is important for survival and where nurses have a central role in detection and subsequent control.

► **A theory-based randomised controlled trial to increase delivery of behaviour change interventions by healthcare professionals**

KEYWORTH, C., ARMITAGE, C. J., JOHNSON, J., *et al.*
2026

Social Science & Medicine 388: 118729.

<https://doi.org/10.1016/j.socscimed.2025.118729>

Background Public health policies require healthcare professionals to incorporate health behaviour change interventions (HBCIs) into routine consultations. This study tested whether an “if-then” planning intervention could enhance HBCI delivery. Methods A randomised controlled trial involving 1008 UK NHS healthcare professionals compared an intervention group, who formed “if-then” plans, with an active control group. Data were collected at one, two, twelve, and thirteen months. Primary and secondary outcomes included the proportion of patients receiving HBCIs, time spent delivering HBCIs, and healthcare professionals’ perceived capabilities, opportunities, and motivations. Results The intervention group showed more sustained improvements in HBCI delivery over time compared to the control group, although the between-group difference at the final follow-up (T4) was not statistically significant. The intervention group significantly increased HBCI delivery between T1 and T2 (mean difference = 3.74; $p = .009$), and between T2 and T3 (mean difference = 4.45; $p < .001$), with delivery remaining higher at T4. The control group showed a significant increase only between T1 and T2 (mean difference = 8.79; $p < .001$). Statistically significant improvements were observed in psychological capability, reflective motivation, and automatic motivation to deliver HBCIs, particularly within the intervention group. Discussion The if-then planning intervention led to sustained improvements in HBCI delivery, with the intervention group showing significant increases between T1 and T2, and between T2 and T3, and maintaining higher delivery at T4. Although the final time point showed no significant

between-group difference, findings support “if-then” planning as a practical strategy to integrate HBCIs into routine care.

► **Health reform implementation during poly-crises: a qualitative study on health workforce perspectives in Finland**

KIHLSTRÖM, L., VIITA-AHO, M., KESKIMÄKI, I., *et al.*
2026

Health Policy 163: 105499.

<https://doi.org/10.1016/j.healthpol.2025.105499>

Background Health system reforms have been ubiquitous in high-income countries during the past decades, yet research on how reform implementation is experienced by the health and care workforce (HCWF) remains scant. This is a critical omission, given that the recruitment and retention of the HCWF is recognized as one of the key challenges of health systems globally, and one which health system reforms often set out to solve. Objective To study how the implementation of a large-scale health system reform in Finland has been experienced by the HCWF in primary health care. Methods Qualitative interviews mainly with physicians, registered nurses, and licensed practical nurses ($n=48$) were conducted in regions’ three primary health care (PHC) centers in Jan 2024–Nov 2024. Interviewees were identified through snowball and purposive sampling. The data were analyzed through an iterative process consisting of both deductive and inductive elements. Results The results point to misalignment between the reform’s intended policy objectives and on-the-ground experiences of the HCWF in PHC in Finland. This has led to a sense of demoralization among the HCWF and impacts how they interpret the legitimacy and legacy of the reform. The data also bring forward factors which strengthen the engagement of the HCWF in PHC which is crucial for overall system change and reform implementation. Conclusions Our findings have critical implications for the implementation and leadership of health system reforms in PHC. HCWF involvement can be a win-win situation for the system and the workforce, and failure to involve them can further deepen the issue of HCWF shortages in PHC.

► **The impact of primary care networks on emergency hospitalisations in the English NHS: an interrupted time series analysis**

KOVACEVIC, L., FORBES, L., ASHRAFIAN, H., *et al.*
2025

Health Policy 165: 105524.

<https://doi.org/10.1016/j.healthpol.2025.105524>

ABSTRACT Recent years have seen an emergence of collaborative primary care models in the English National Health Service and other international health systems. Primary Care Networks (PCNs) were introduced in England in July 2019, marking the first time collaboration between general practices was incentivised through a nationwide policy. While participation was not mandatory, nearly all general practices joined a PCN, largely due to strong financial incentives. Our study aim was to estimate the impact of PCNs on emergency hospitalisations using an interrupted time series design. Quarterly data between October 2016 and March 2023 from the North West London Whole Systems Integrated Care dataset was used to construct two primary outcomes: all-cause and ambulatory care sensitive conditions (ACSC) emergency hospitalisations, as well as Accident and Emergency attendances, considered as a secondary outcome. Furthermore, we analysed whether the impact of PCNs varied based on practice characteristics. A reduction in all-cause and ACSC hospitalisations was observed following the PCNs' introduction, until the start of the COVID-19 pandemic. The analysis also revealed a smaller reduction in ACSC hospitalisations among practices with more deprived patient populations and larger populations of patients with long-term conditions. While PCNs' implementation appears to have led to a reduction in emergency hospitalisations in North West London, this effect was only observed in the very short term as it stopped with the COVID-19 pandemic. Future studies should examine the effect across England and evaluate their continued impact.

► **Community health workers: a comparative assessment of capacities of a global policy approach in selected European health systems**

KUHLMANN, E., LOTTA, G., BURAU, V., *et al.*
2026

Health Policy 165: 105541.

<https://doi.org/10.1016/j.healthpol.2025.105541>

Background Interest in community health workers (CHWs) and the benefits for health systems are growing globally, but research is focused on low- and middle-income countries and high-income Anglo-American countries. **Objective** This comparative assessment focuses on community health systems and health and care workers as advocates and boundary spanners, aiming to connect global evidence to high-income European countries and assessing the capacities for transformative change. **Methods** A qualitative comparative approach and case study design were chosen, aligning global expertise of the CHW pioneers, Brazil and South Africa, and selected European countries: Denmark, Germany, Netherlands, Portugal, Romania, UK/England. Case studies were collected in April/May 2025, drawing on country experts and secondary sources; thematic analysis was performed following an explorative interactive consensus-based procedure. **Results** European countries create diverse occupational pathways into health systems that move beyond primary healthcare, clinical tasks, and CHWs as defined globally. Promising capacities emerge if occupational programs are interconnected with health system reform, community-based social and care services, the establishment of a regulated multi-professional community-centred group, and strengthening of public health and social support services. No country uses these capacities effectively. **Conclusions** Community-centred health and care workers need greater attention in Europe to drive health system transformations and global policy learning.

► **State Policy Strategies to Promote the Recruitment and Retention of the Behavioral Health Workforce**

LAST, B. S. ET ZHU, J. M.

2025

The Milbank Quarterly 103(S1): 50-74.

<https://doi.org/10.1111/1468-0009.70013>

Policy Points To address persistent gaps in behavioral health care access and availability, particularly for underresourced populations, state policymakers have implemented four core strategies to address the shortage of behavioral health providers serving the Medicaid population. In this paper, we describe each of these state policy strategies, discuss their potential workforce and service impacts, and highlight unanswered questions about their effectiveness and implementation. Altogether, our review of these policy strategies suggests that rigorous evaluation of these state

policy strategies is needed along with broader transformations to the behavioral health system to sustainably grow and retain the workforce in the long term.

► **Impact of COVID-19 on primary care consultation mode in England: An interrupted time series analysis**

MESIANO, N. ET SANTOS, R.

2026

Health Policy 164: 105502.

<https://doi.org/10.1016/j.healthpol.2025.105502>

Background The COVID-19 pandemic significantly disrupted healthcare delivery worldwide, and general practice in England was no exception. The adoption of remote consultations in primary care increased sharply during the pandemic. However, there is no evidence that the adoption of remote consultation will continue in the long term. **Objective** Analyse the long-term effects on primary care face-to-face and telephone consultations in England after the change towards remote consultation during COVID-19 pandemic. **Method** We use Interrupted Time Series analysis to understand the long-term effects on primary care face-to-face and telephone consultations in England at both national and regional levels. **Results** There was a shift in consultation patterns during and after the pandemic. Face-to-face consultations experienced a significant and immediate decline following the introduction of restrictions. However, they gradually increased and returned to pre-pandemic levels after restrictions were lifted, indicating that most healthcare needs still require in-person contact. Telephone consultations rose sharply during the pandemic. Although their use declined after restrictions eased in July 2021, they remained above pre-pandemic levels. **Conclusion** The COVID-19 pandemic profoundly changed how general practice consultations are delivered in England, prompting a rapid shift to remote consultation methods. While telephone consultations surged when face-to-face contact was restricted, this increase was not sustained in the long term. Although remote consultations remained above pre-pandemic levels, they did not fully replace in-person visits. This suggests a dual use of resources rather than a substitution. Policy efforts should focus on balancing and supporting both remote and face-to-face consultation models.

► **From recruitment to retention of young doctors: a comparative analysis of policies in Poland and the United Kingdom**

MICHALSKA, K., AQUINES, A. G., MCVEY, L., *et al.*

2026

Health Policy 164: 105513.

<https://doi.org/10.1016/j.healthpol.2025.105513>

Background European healthcare systems are facing shortages of physicians, which increases pressure on the recruitment and retention of young doctors. **Objective** This article aims to compare the solutions implemented for young doctors in Poland and the United Kingdom and to identify transferrable solutions between the systems. **Methods** A comparative analysis of public policies was conducted in April 2025 and was updated in August 2025 based on the five pillars of the WHO 2023–2030 framework and the healthcare labour market. The analysis comprised documents of the governments and international health organisations, legal acts, scientific and grey literature and additional consultations with national experts. **Results** In Poland, the remuneration of medical doctors (including interns and residents), as well as admission limits and number of institutions educating doctors, significantly increased. However, a comprehensive, long-term resource planning strategy is still lacking. In the United Kingdom, the National Health Service Long Term Workforce Plan and 10 Point Plan were implemented to improve resident working conditions, complemented by wellbeing and flexible work organisation programs. **Conclusions** The policies for young doctors in Poland and the UK show differences in scale, consistency, and sustainability, but the comparison reveals a similar need for a long-term integrated strategy. Key issues include expanding training tailored to supervisory capabilities; replacing fragmented workplace-based incentive packages; making flexibility, mentoring and psychological safety permanent features of young doctors' work; and adapting curricula to digital, team-based care.

► **Adapting Healthcare Workforce Distribution Amid Multiple Crises: A 12-Year Analysis of Physician Allocation Patterns in Turkey (2013-2024)**

ÖNTAŞ, E. ET YAVUZ, C. I.

2026

Health Policy 165: 105523.

<https://doi.org/10.1016/j.healthpol.2025.105523>

Background Health systems worldwide face compound

crises that test workforce resilience and equity. Turkey's centralized healthcare system offers a critical case to examine how governance models perform under sustained, sequential shocks. Objective To assess how Turkey's compulsory service-based physician distribution system responded to major crises over the past decade and to introduce a novel metric for evaluating workforce retention efficiency. Methods This 12-year longitudinal ecological study (2013-2024) analysed Ministry of Health physician stock (active density) and flow (new appointments) data across 81 provinces. A "retention efficiency" metric ($\Delta\text{Stock}/\text{Flow}$) quantified system performance, and distributional inequality was assessed. Quasi-experimental methods, including difference-in-differences and interrupted time series analyses, assessed the impacts of the Syrian refugee influx, COVID-19 pandemic, and the 2023 earthquakes. Results Physician density under MoH increased by 57% (2013-2023), yet regional inequality worsened markedly (Weighted-Gini:0.079→0.116;+47%). A "revolving door" dynamic was identified: western regions retained physicians efficiently(>0.95), while peripheral eastern regions suffered catastrophic retention inefficiency(<0.10), rendering compulsory service ineffective. Crisis response phenotypes varied significantly. The 2023 earthquakes triggered a "volatile surge" with dose-response characteristics: the 3 epicentre provinces showed +239% increase (ITS:+36.4;95%CI:35.4–37.4), declining 58.3% by 2024. In contrast, the Syrian refugee influx elicited an "integrated absorption" pattern, with no significant targeted response (DiD:0.80;p=0.574) despite increased demand. Conclusion Compulsory service enables short-term absorptive capacity but fails to ensure lasting equity. The retention efficiency metric exposes hidden inefficiencies that conventional density measures miss. Transitioning from coercive placements toward bundled incentives and investment in professional ecosystems is essential to achieve sustainable workforce resilience.

► **Provision of community health services and use of hospital care in England: Nationwide retrospective observational study.**

PARKINSON, B., SUTTON, M. ET MEACOCK, R.
2026

Health Policy 165: 105538.

<https://doi.org/10.1016/j.healthpol.2025.105538>

Background Expanding healthcare provision in the community is a common policy solution for reducing

hospital pressures. While there is some evidence that strengthening primary care can influence hospital use, little is known about the impact of community health services such as nurse-led care delivered in patients' homes. Objective To examine whether the size of the community health services workforce influences use of hospital care. Methods Multivariable regression of the size of the community nursing and nursing support workforce against rates of hospital use by patients aged 65+ in English local authorities in 2019/20, accounting for population needs and availability of other services. Results On average per 1,000 population aged 65+, there were 4.3 FTE community staff employed, 440 planned admissions, 267 emergency admissions (of which 66 were for ambulatory care sensitive conditions), 465 emergency department attendances, and 4,204 outpatient appointments. Unadjusted positive associations of community workforce provision with measures of emergency hospital use were explained by population characteristics. Community workforce provision was not significantly associated with any hospital use outcomes in the fully adjusted analyses. Sensitivity analyses confirmed these null findings. Conclusions We found no evidence that the size of the community workforce was associated with hospital activity. Despite substantial geographical variation in the size of the workforce, areas with more community staff did not have lower hospital use. Expanding community services alone is unlikely to reduce hospital activity at the system level. Direct intervention in the hospital sector will likely be required to achieve this aim.

► **Impact of quality clusters on antibiotic prescribing patterns. A difference-in-differences study from Danish general practice**

PEDERSEN, L. B., BUNDEGAARD, M., FREDSLUND, E. K., *et al.*

2026

Health Policy 163: 105493.

<https://doi.org/10.1016/j.healthpol.2025.105493>

Globally, a more rational use of antibiotics is needed to face the threat of antimicrobial resistance. In 2018, quality clusters were introduced in Danish general practice as a new quality improvement initiative. In the clusters, general practitioners engage in self-selected quality improvement topics, such as antibiotics prescribing. This study investigates whether engaging with antibiotics as a topic in quality clusters improves antibiotics prescribing, and whether choice and number of

quality improvement strategies matter for behaviour change. We link register data on redeemed antibiotics prescriptions from Danish general practice from 2015-2020 with survey data from 2020 on whether, when, and how practices in clusters engaged with antibiotics as a quality improvement topic. We use a difference-in-differences approach including general practice fixed effects and practice-averaged time-varying patient population characteristics in linear regressions models. We find that practices engaged with antibiotics as a quality improvement topic increase their proportion of narrow spectrum antibiotics prescriptions compared to other practices, while there is no difference in changes in the total number of prescribed antibiotics. Neither the choice nor the number of surveyed quality improvement strategies seem to influence the behavioural outcomes. In conclusion, engaging in antibiotics in quality clusters to some extent improved antibiotic prescribing.

► **Interventions aiming to change multiple healthcare professional behaviors: A systematic review**

SILVA, C. C., MARQUES, M. M., VAN ALLEN, Z., *et al.*
2025

Social Science & Medicine: 118760.
<https://doi.org/10.1016/j.socscimed.2025.118760>

Background Healthcare professionals' (HCPs) routinely engage in multiple different clinical actions. We aimed to identify and synthesize the characteristics of multiple behavior change interventions in HCPs. Methods Five electronic databases were searched up to June 2025 for randomized trials of interventions aiming to change more than one clinical behavior, including behavior change advice. Two reviewers independently screened and extracted 20% of the data. Quality was assessed using Cochrane's Risk of Bias 2 tool and content of interventions was coded using Behavior Change Ontologies. Evidence was narratively synthesized. Results Seventeen studies were included, most targeting physicians. Clinical behaviors varied in type and specificity and were inductively categorized into seven upper-level domains: 'provision of behavior change advice', 'screening/assessment/measurement', 'prescription of medication', 'referrals', 'treatment', 'diagnosis' and 'medical history taking'. Interventions were mostly brief (median=5 days) and delivered through a combination of face-to-face and at-a-distance modes of delivery (41%) and in group settings (47%). Only 3 trials reported using theory to inform intervention development (18%). Each intervention used at least one

behavior change technique (BCT; 22 BCTs identified). The most frequent BCTs were 'set behavior goal' (90%), 'add objects to the environment' and 'present information from credible influence' (63% each). Conclusions Current interventions are highly heterogeneous in the clinical behaviors targeted for change and approaches to their measurement. Greater recognition of the multiple behavior nature of such interventions, and on reporting their content accordingly, may contribute to understanding whether and how best to intervene on more than one clinical behavior. Registration PROSPERO (CRD42022327108) and Open Science Framework (<https://osf.io/g7mwf/files/yfqrt>).

► **Périmètre d'attractivité territoriale de la maîtrise de stage : étude de cohorte rétrospective**

TAHA, A., THÉBAULT, J. L., RENARD, V., *et al.*
2025

Santé Publique 37(4): 185-194.
<https://doi.org/10.3917/spub.254.0185>

Introduction : Les stages réalisés en médecine générale durant le 3^e cycle de médecine générale permettent d'attirer des médecins sur leur territoire. Nous ignorons dans quel périmètre géographique cette attractivité s'exerce. But de l'étude : Ce travail a pour objectif d'évaluer le périmètre d'attractivité des stages de médecine générale. Méthode : Evaluation rétrospective d'une cohorte constituée d'étudiants inscrits en 3^e cycle de médecine générale entre 2012 et 2020 et ayant une activité de médecin généraliste installé en libéral ambulatoire. Description du lieu d'installation à l'échelle de la commune, du territoire « vie-santé » ou du canton. Comparaison entre le lieu d'installation et les lieux de stage réalisés en médecine générale. Résultats : Une cohorte de 1 625 anciens étudiants installée en libéral a été constituée. Parmi eux, 131 (8,1 %) se sont installés dans le même cabinet, 217 (13,4 %) dans la même commune, 219 (13,5 %) dans le même territoire vie-santé et 239 (14,7 %) dans le même canton. À noter que 476 (29,3 %) anciens étudiants se sont installés en dehors de l'île-de-France. Les installations étaient majoritairement réalisées sur le lieu du stage de niveau 2 (50,7 %) et du niveau 1 (43,8 %). Conclusions : Le périmètre d'attraction des stages s'exerce principalement à l'échelle de la commune et peu au-delà. Le taux d'installation modeste des anciens étudiants suggère que la maîtrise de stage attire également des médecins qui ne se sont pas formés sur le territoire. Ce point pourrait faire l'objet d'autres travaux

Health Systems

► **Economic evaluation of participation in Community Led Organisations for individuals living in disadvantaged areas in the UK**

MASON, H., IRVINE, N., MANOUKIAN, S., *et al.*
2026

Social Science & Medicine 389: 118761.
<https://doi.org/10.1016/j.socscimed.2025.118761>

This paper presents an economic evaluation of community-led and -owned organisations that deliver activities to support health and wellbeing. Because community-led organisations (CLOs) are a vital part of the social and solidarity economy, they increasingly feature in public health policies targeting disadvantaged populations. However, little is known about the value CLOs generate as few economic evaluations of them exist and those available focus on isolated activities (such as exercise classes) and/or specific populations (e.g., men-only collectives). The novelty of our work lies in the inclusion of multiple CLOs, comprehensive coverage of their activities, breadth of participants studied, and control group methodology applied in creating new knowledge of the health and wellbeing outcomes of CLOs and resources consumed to achieve them. We conducted cost-effectiveness and cost-consequence analyses of data collected via a 12-month longitudinal study. We compared 331 CLO participants in 14 UK-based CLOs to a ‘do nothing’ synthetic control group (n=100). Health and wellbeing were measured using the ICECAP-A capability measure for adults, EuroQol EQ-5D-5L, Short-form Warwick Edinburgh Mental Wellbeing Scale and the Revised Social Connectedness Scale. Resource use data included health, social care, and other community sector resources. Data collection occurred at four-points over the study period supported by publicly available accounts and data provided by each CLO. We found an incremental cost per year in full capability of £35,813 and an incremental cost per quality adjusted life year of £29,827. Statistically significant improvement in both social connectedness, and mental wellbeing were observed over the 12 month follow up. This work supports CLOs as an intervention to improve health and wellbeing in disadvantaged communities and identifies challenges for traditional evaluation methodology with regards to costing and comparator groups.

► **The Affordable Care Act: At the Nexus of Politics and Policy**

MORIZE, N.
2026

Journal of Health Politics, Policy and Law 51(1): 121-124.
<https://doi.org/10.1215/03616878-12171262>

Numerous scholars have explored the processes that led to the enactment of the Affordable Care Act (ACA) in 2010. In *The Affordable Care Act: At the Nexus of Politics and Policy*, James M. Brasfield offers a comprehensive analysis that not only covers the ACA’s passage but also nearly fifteen years of its implementation and reform as well as retrenchment efforts. Unlike many works that focus on isolated aspects of policy change, the originality of this book lies in its chronological synthesis of agenda setting, enactment, and a decade of postenactment implementation and reforms. Additionally, Brasfield provides a more in-depth review of the legislative process than previous studies have, making it a valuable case study for anyone interested in understanding health policy in detail.

► **Backlogs, waiting times and waiting lists of elective surgeries across OECD countries**

SICILIANI, L., LAFORTUNE, G., CANAUD, M. C., *et al.*
2026

Health Policy 163: 105478.
<https://doi.org/10.1016/j.healthpol.2025.105478>

Background Many OECD countries suspended elective (non-emergency) care during the pandemic to divert efforts towards COVID-19 patients, which generated a backlog of patients. **Objective** This study measures the extent to which waiting times and volume changed over time before and after COVID-19 in OECD countries (between 2016-2023). We test whether COVID-19 had a different effect on the waiting time of the patients on the list versus the wait of patients treated, two common measures of waiting times. It discusses how waiting times and volume can be used as measures of health system resilience for elective care. **Methods** The study uses data on a selection of high-volume elective surgeries and OECD countries that report waiting times

for patient on the list or from addition to the list to treatment. We use regression methods to quantify the extent to which waiting times increased and volumes decreased after the pandemic across OECD countries. Results We find that the wait on the list increased on average by 27-30% in the first three years. In contrast, the wait to treatment increased only to a small extent and the effect was not statistically significant. Volume reduced on average by 19% and 10% in the first two years. There were heterogeneous effects across countries, but these do not appear to be systematically related to health spending, physicians and acute beds. Conclusion Measures of health system resilience for elective care should monitor both the wait on the list and the wait to treatment, in addition to volumes.

► **Lots of Pain for Little Gain: Three Decades of Medicaid Estate Recovery**

SPISHAK-THOMAS, A., SANDOE, E. ET HOWARD, H.
2026

Journal of Health Politics, Policy and Law 51(1): 101-119.

<https://doi.org/10.1215/03616878-12166749>

Since Congress enacted Medicaid estate recovery into law in 1993, there have been few changes to the policy and little research to investigate its effectiveness. Under Medicaid estate recovery—a response to the rising and uncertain costs associated with long-term custodial care among a rapidly aging American population—states have the right to track former Medicaid beneficiaries' assets and seek recovery from their estate after their death. Although it makes an insignificant dent in state budgets, Medicaid estate recovery can nonetheless have a lasting impact on the lives of families subject to its repayment requirements. For low-income families where homeownership is their primary source of wealth, policies aimed at homeowners may exacerbate longstanding disparities in wealth and disproportionately burden Black and Hispanic families. Recently, some states have initiated policy changes to address problems with Medicaid estate recovery, and similar legislation has also been introduced in Congress. Such reforms, if more widely adopted, may improve the financial circumstances of surviving family members of deceased Medicaid beneficiaries.

► **Les réformes des systèmes de santé en Europe**

LES TRIBUNES DE LA SANTÉ
2025

Les Tribunes de la santé 86(4): 104p.

<https://stm.cairn.info/revue-les-tribunes-de-la-sante-2026-1>

A travers les articles proposés, ce dossier veut aider à mieux appréhender les défis que doivent relever les pays européens pour préserver et moderniser leurs systèmes de santé et d'assurance maladie. Avec la conviction qu'ils permettront également de mieux mesurer la richesse d'une organisation de la protection de la santé qui a pour ambition de proposer à la population des actions de prévention et de garantir un égal accès aux soins à toutes celles et tous ceux qui sont confrontés aux douloureuses échéances de la maladie ou de l'accident.

► **The influence of public health organization on response to the COVID-19 pandemic in four Canadian provinces: A comparative qualitative analysis**

USHER, S., ALLIN, S., GAUTIER, L., *et al.*
2025

Health Policy OPEN 9: 100146.

<https://doi.org/10.1016/j.hpopen.2025.100146>

Background Studies of COVID-19 pandemic responses reveal shortcomings that may relate to the organization of public health systems. Objective This study uncovers the organizational factors that may strengthen pandemic responses in high-income countries through a comparative analysis of four Canadian provinces. Methods We undertook a qualitative multiple case study, collecting data through document review and 103 interviews with government and non-governmental actors involved in pandemic response. Analysis explored how differences in the organization of provincial public health systems influenced decision-making, advisory, coordination and adaptation processes. Results The scale of the pandemic positioned the Premier as legitimate decision-maker in all provinces regardless of the distribution of authority in their public health systems. Capacity for generating public health advice was increased through existing or new organizations and highlighted the advantage of links to university expertise. All public health systems relied on healthcare resources for testing programs despite differences in the integration of public health under healthcare governance structures; centralization of

healthcare governance was a facilitator. Adapting pandemic control measures to population needs was supported by linkages between organizations capable of apprehending needs and organizations that made decisions. Conclusions This study builds on the

literature of pandemic responses across high-income countries and uncovers organizational factors that may enhance agility to rapidly expand capacities, connect actors for emergency responses, and strengthen public health systems.

Travail et Santé

Occupational Health

► **The effects of commuting and working from home arrangements on mental health**

BOTHA, F., KABÁTEK, J., MEEKES, J., *et al.*

2026

Social Science & Medicine 389: 118812.

<https://doi.org/10.1016/j.socscimed.2025.118812>

In this study, we quantify the effects of commuting time and working from home (WFH) arrangements on the mental health of Australian men and women. Leveraging rich panel-data models together with home-job-spell fixed effects, we first show that adverse effects of commuting time are modest in magnitude and manifest only among men with poor levels of mental health (0.01 SD decrease per 10-min increase of commuting time). Second, we show that WFH arrangements have large positive effects on women's mental health, provided that the WFH component is large enough. The effects are once again concentrated among individuals with poor levels of mental health (0.2 SD increase corresponding to working from home 50–75 % of the time). This uncovered contingency of effect sizes on the reported levels of mental health is novel and extends beyond Australia: we show that it also underlies the adverse effects of commuting time on the mental health of British women. Our findings highlight the importance of targeted interventions and support for individuals who are dealing with mental health problems.

► **The Effects of Paid-Sick-Leave Mandates on Care Provision**

GUO, X. ET PENG, L.

2026

Health Economics 35(1): 102-117.

<https://doi.org/10.1002/hec.70049>

ABSTRACT The U.S. paid-sick-leave (PSL) mandates allow private-sector workers to take time off for their own or family members' illnesses. However, the impacts of these laws on workers' care seeking and provision activities are relatively understudied. We address this gap by exploiting cross-state variation in mandate enactment between 2012 and 2019. Using data from the American Time Use Survey, our difference-in-differences estimates show little evidence that PSL mandates affect the probability of spending time on overall care provision at the population level. However, we find a positive association between the mandates and care provided to adults by workers in industries with larger exposure to the policies. Our results provide empirical support for the potential of paid leave policies to help workers who otherwise have limited access to the benefit reconcile workplace responsibilities and caregiving.

► **Sickness absence with common mental disorders and antidepressant prescriptions across different employment branches during as compared to before the Covid-19 pandemic—an observational study covering the Swedish population aged 18–65 years**

KIRCHNER, S., GÉMES, K., JOSEFSSON, P., *et al.*

2025

European Journal of Public Health 35(6): 1137-1142.

<https://doi.org/10.1093/eurpub/ckaf145>

Few studies have examined the implications of the Covid-19 pandemic on mental health across different employment branches. This study investigated the impact of the pandemic on long-term sickness absence (SA) with common mental disorders (CMDs)

and antidepressant prescriptions in different employment branches and age groups in Sweden. Using national registers, we observed the Swedish population (18–65 years) with gainful employment quarterly from 2018 to 2021. An interrupted time-series design was employed to examine changes in trends of incidence rates (IRs) for (i) long-term (>90 days) SA with CMDs and for (ii) antidepressant prescriptions across eight employment branches during versus pre-pandemic. Analyses were stratified by age group. There was no evidence of outcome changes in the entire working age population. However, compared to pre-pandemic levels, the IRs of long-term SA with CMD increased by 5.9% per quarter for those working in the cultural sector [95% confidence interval (CI): 2.2%–9.8%], 3.4% in trade and transportation (95% CI: 0.4%–6.4%), and 5.5% in manufacturing and services (95% CI: 1.5%–9.7%) as well as among individuals aged 56–64. Incident antidepressant prescription rates were marginally higher for workers in construction (1.1% annual increase; 95% CI: 0.1%–2.1%), culture (1.4%; 0.7%–2.0%), and trade and transportation (0.9%; 0.1%–1.7%). While the risk of CMD-related long-term SA or incident antidepressant prescription in Swedish workers did not appear to be impacted by the pandemic, certain employment branches and older individuals were negatively affected in terms of both outcomes. Targeted countermeasures and initiatives to improve well-being are necessary for vulnerable groups.

► **Fréquences d'exposition aux principaux facteurs de risque biomécaniques d'usure professionnelle chez les femmes et les hommes dans la cohorte CONSTANCES**

MORVAN, G., BODIN, J., MAJOR, M. E., *et al.*

2025

Santé Publique 37(4) : 35-46.

<https://doi.org/10.3917/spub.254.0035>

Introduction : Dans le cadre de la réforme des retraites de 2023 en France, un fonds pour la prévention de l'usure professionnelle (FIPU) a été créé pour limiter les expositions à trois critères : les manutentions manuelles de charges, les postures pénibles et les vibrations mécaniques. Cette étude vise à identifier les familles professionnelles les plus exposées aux trois critères du FIPU ainsi qu'à l'ajout d'un facteur de risque biomécanique supplémentaire (répétitivité). Méthode : Les analyses sont basées sur des données transversales de la cohorte CONSTANCES (Consultants des centres

d'exams de santé). Les expositions aux trois critères du FIPU et à la répétitivité ont été décrites selon les familles professionnelles (FAP). Résultats : Les FAP les plus exposées à au moins un des trois critères du FIPU, chez les hommes, sont les ouvriers qualifiés du bâtiment (gros et second œuvre : 95,8 % et 88,1 %) et du formage de métal (86,0 %). Chez les femmes, les FAP les plus touchées sont les aides à domicile/aides ménagères (80,3 %), les aides-soignantes (79,2 %) et les assistances maternelles (77,1 %). L'ajout du facteur répétitivité augmente la proportion d'exposés, notamment chez les femmes, et fait ressortir de nouveaux métiers comparativement à ceux obtenus avec les critères du FIPU. Discussion : Cette étude apporte un enrichissement en fournissant des données quantitatives précises sur l'exposition aux facteurs de risque biomécaniques en France, avec une différenciation selon le sexe. En ce sens, elle permet de mieux orienter les facteurs à considérer pour la prévention de l'usure professionnelle.

► **Multimorbidity and the indirect cost of productivity loss from health-related work absenteeism in Belgium**

TRAN, P. B., BERETE, F., DE CLERCQ, B., *et al.*

2025

European Journal of Public Health 35(6) : 1129-1136.

<https://doi.org/10.1093/eurpub/ckaf063>

This cross-sectional observational study aims to estimate the number of days absent from work due to health-related problems among employed individuals with multimorbidity and to quantify the lost productivity value from these absences. Data were obtained from the Belgian Health Interview Survey 2018, comprising employed individuals aged 15-64 (N = 4096). We examined 12 chronic conditions and 57 dyads. The Human Capital Approach was used by multiplying the reported number of days absent by the average wage per person per day, utilizing stratified gross wages from the Belgian Statistical Office. Approximately one-third of the study population reported multimorbidity. For individuals with zero to four+ chronic conditions, mean days of absence were 5.5 (95% CI: 2.3-8.8), 6.8 (95% CI: 2.9-10.7), 14.8 (95% CI: 10-19.6), 24 (95% CI: 17.8-30.2), and 36.2 (95% CI: 30.4-42), respectively. Depression (€3089; 95% CI: 2129-4049), diabetes (€2315; 95% CI: 962-3668), arthropathies (€1972; 95% CI: 1101-2844), and cancer (€1848; 95% CI: 598-3099), as standalone conditions, were associated with the greatest productivity losses. The effects were amplified up to seven times with the co-occurrence of multiple chronic

conditions. We estimated 34.2 million days absent or €7.5 billion in lost productivity due to health-related work absenteeism among working-age employed individuals with multimorbidity in 2018. At the population level, the coexistence of two musculoskeletal disorders was linked to the highest aggregated productivity loss. At the individual level, the coexistence of a mental health condition and a somatic condition was associated with the highest average productivity loss per capita. The indirect cost due to health-related absence from work for individuals with multimorbidity in Belgium is high, and in many cases, exceeds the direct cost of treatment.

► **Global, Regional, and National Burden of DALYs Attributable to Occupational Risks, 1990-2021: Trends and Projections to 2030**

ZONG, X., HU, H., LI, H., *et al.*

2026

Social Science & Medicine 389: 118810.

<https://doi.org/10.1016/j.socscimed.2025.118810>

Abstract: Background Occupational risks remain an important yet underrecognized contributor to the global burden of disease. Understanding long-term trends and regional disparities in occupational health risks is essential for effective prevention. Methods We used data from the Global Burden of Disease Study (GBD) 2021 to estimate Disability-Adjusted Life Years (DALYs) attributable to six major occupational risk

factors (occupational carcinogens, asthmagens, noise, ergonomic factors, injuries, and occupational particulate matter, gases, and fumes) across 204 countries and territories from 1990 to 2021. We used joinpoint regression to identify significant trend shifts and average annual trends. Furthermore, we conducted decomposition analyses to identify drivers of change and applied Bayesian age-period-cohort models to project DALYs to 2030. Results were disaggregated by sex, region, and Socio-demographic Index (SDI). Results Between 1990 and 2021, total DALYs attributable to six selected occupational risk factors increased from 73.0 million to 77.2 million, while the global age-standardized DALYs rate declined significantly (-1.72% per year; 95% CI: -1.78 to -1.66). The burden was consistently higher in males and low-SDI regions. Population growth and ageing were the primary drivers of increasing DALYs, while reductions in exposure levels had limited or counterbalancing effects. Occupational injuries and ergonomic factors were the leading contributors in low-SDI settings, whereas carcinogen-related DALYs predominated in high-SDI countries. Notably, the burden from occupational noise continued to rise globally. Inequality analyses revealed persistent disparities, including in high-income regions. Conclusions Although substantial progress has been made in reducing age-standardized rates, occupational risks still contribute meaningfully to global health loss. Region-specific and equity-oriented strategies remain essential to address preventable occupational disease burden, particularly in low-resource settings.

Vieillesse

Ageing

► **Strategies to improve recruitment, retention, working conditions, and skills among the long-term care workforce: An umbrella review of existing evidence**

BADACHE, A. C., DOBROSAVLJEVIC, M. ET BARBER, S. L.

2026

Health Policy 163: 105496.

<https://doi.org/10.1016/j.healthpol.2025.105496>

Background Population ageing has an impact on the

need for long-term care (LTC) because functional limitations increase with age. Most older adults require support from family or formal LTC providers; thus, there is an urgent need for strategies to strengthen LTC workforce recruitment and retention. Objective To conduct an umbrella review to assess the strategies used to improve recruitment, retention, working conditions, and skills development of the formal LTC workforce. Methods Following the PRIOR guidelines and after protocol registration on PROSPERO, we conducted an umbrella review and searched four data-

bases: MEDLINE, Embase, CINAHL, and Web of Science for intervention studies between 1946 and June 2024. Eligible studies were systematic reviews of interventions targeting formal LTC workers caring for adults aged 60 years and older. Two reviewers screened, extracted data, and appraised methodological quality. Results Of 10,475 screened articles, 19 reviews met the inclusion criteria. Continuing professional development and peer-led training consistently improved staff knowledge and competencies, and sometimes job satisfaction and turnover. The evidence for well-being programs and policies was limited and heterogeneous; overall, most reviews were of low quality. Conclusions Future research should improve the context and workforce roles, adopt standardized outcomes, and rigorously evaluate organizational and policy interventions.

► **Vieillir avec une maladie neurodégénérative**
Redéfinitions de la valeur sociale au prisme
du genre et de l'âge

BÉLIARD, A. ET BLUM, P.
2025

Travail, genre et sociétés n° 54(2): 79-95.
<https://doi.org/10.3917/tgs.054.0079>

À la lumière d'enquêtes ethnographiques auprès de personnes diagnostiquées et de leur entourage, et en restituant les histoires particulières de deux femmes, cet article aborde l'expérience sociale de la maladie d'Alzheimer et de la maladie de Parkinson, à l'intersection entre processus de maladie et processus de vieillissement. Ces deux maladies neurodégénératives entraînent de progressives pertes de capacités et parfois d'autonomie. Elles exposent les personnes au risque de ne pas pouvoir tenir les attentes liées à leur âge statutaire, selon les normes sociales et de genre. En explorant comment les personnes définissent, vivent et anticipent les symptômes et conséquences de leur maladie, nous montrons que celle-ci menace et redéfinit ce qui fait leur valeur sociale, à leurs yeux et à ceux de leurs proches. Nous étudions les processus par lesquels la maladie fragilise cette valeur et les stratégies et ressources déployées, selon les contextes et les scènes de la vie sociale, pour la préserver ou la reconstruire.

► **Inégales vieillesse**

BENQUET, M., LEMARCHANT, C. ET ROSSIGNEUX-MÉHEUST, M.
2025

Travail, genre et sociétés 54(2): 21-24.
<https://doi.org/10.3917/tgs.054.0021>

La question de la visibilité du grand âge est complexe : il fait simultanément l'objet d'attentions des politiques publiques depuis plus de deux siècles, mais aussi d'une forme de cécité collective quand il s'agit de se pencher sur l'expérience sociale de cet âge de la vie. Cet aveuglement est d'ailleurs redoublé quand ces personnes sont des femmes renvoyées non seulement à leur absence de productivité, mais aussi à leur non-reproductivité [Palazzo-Crettol *et al.*, 2022]. Au-delà des stéréotypes, combien de romans ou de films placent-ils la focale d'une fiction sur les affects, les aventures ou les amours de personnes âgées ? En dehors des affaires de maltraitances et de la série de l'été 2024 du journal Le Monde « Raconte-moi ta vieillesse », quand la presse généraliste prend-elle le temps de documenter la vie quotidienne des vieilles et des vieux ? Au sein même de nos disciplines, que pèsent les travaux sur le grand âge par rapport à la somme de ceux que l'enfance et la jeunesse ont suscité ? Même si la vieillesse s'est constituée en champ de recherche en sociologie et en économie, l'analyse de la vieillesse par l'expérience de celles et ceux qui la vivent demeure en marge des épistémologies de la domination.

► **Décès du conjoint et mobilité résidentielle**
en France : Des désavantages cumulatifs
aux âges avancés

CHABOT, T. ET LE ROUX, G.
2025

Population 80(1): 11-40.
<https://doi.org/10.3917/popu.2501.0011>

Un mécanisme souvent discuté en sociologie des parcours de vie est celui de désavantage cumulatif : face aux mêmes chocs biographiques, les individus seraient touchés d'autant plus durement qu'ils disposent de peu de ressources, d'où un accroissement tendanciel des inégalités avec l'avancée en âge. Nous testons ce principe pour le cas particulier de la mobilité résidentielle à la suite d'un veuvage. À partir des données de l'Échantillon démographique permanent (EDP), un panel de grande taille sur la population française hexagonale, et en mobilisant une méthode d'appariement, nous montrons que le veuvage entraîne une surmo-

bilité et une dégradation de la position résidentielle d'autant plus fortes que l'on descend dans la hiérarchie socioprofessionnelle, conformément à l'hypothèse du désavantage cumulatif. Les veufs et veuves plus âgées sont aussi plus impacté-es. En revanche, les conséquences résidentielles du veuvage sont proches pour les hommes et les femmes, à l'exception d'une propension plus forte pour les hommes à entrer en institution. Ces résultats rappellent que la population âgée ne doit pas être considérée comme homogène dans les études sur le vieillissement.

► **Targeting "average Jane": The co-modification of for-profit nursing home care in the Netherlands**

DE BRABANDERE, L., SCHUURMANS, J., VAN DER WOERD, O., *et al.*

2025

Social Science & Medicine 387: 118712.

<https://doi.org/10.1016/j.socscimed.2025.118712>

In the Global North, long-term residential care is increasingly shaped by globally financed, for-profit nursing home chains. Yet little is known about how such initiatives operate and how they interact with public healthcare systems. This article investigates a long-term care facility in the Netherlands backed by global investment capital. Drawing on the concept of co-modification (Asdal & Huse, 2023), defined as the co-creation of goods and services alongside markets and regulatory frameworks, we examine how actors across different layers of the healthcare system collaboratively transform care into a profitable product. Based on ethnographic observations, interviews with care providers and policymakers, and analysis of policy documents, we identify four interconnected practices through which co-modification unfolds: 1) articulating user value, 2) delineating a customer niche, 3) making products by standardizing, and 4) claiming space through legitimacy work and strategic positioning in a health care system. We show how in this process globally financed care providers become increasingly entangled with regular care providers and reshape the healthcare system. In doing so, we extend the concept of co-modification to public healthcare systems under institutional constraints, show what work is needed in such circumstances, and introduce market segmentation as a co-productive mechanism linking valuation practices to the configuration of consumer populations.

► **Evaluating the Effectiveness of an Integral Neighbourhood-oriented Approach for Healthy Ageing: Findings from a Cluster-randomised Controlled Trial in Socioeconomically Diverse Communities**

DUIJSENS, L. J. E., BOLMAN, C. A. W., PEELS, D. A., *et al.*

2026

Social Science & Medicine 390: 118842.

<https://doi.org/10.1016/j.socscimed.2025.118842>

This article reports an effectiveness study of Neighbourhood Active & Connected, a novel neighbourhood-oriented approach to promote healthy ageing among older adults from lower socioeconomic positions (LSPs). This group faces significant health disparities and limited access to preventive care. The intervention aims to enhance physical activity, reduce loneliness, and improve social cohesion and health-related quality of life, while fostering digital engagement to support healthcare access and independence. To evaluate its impact, we conducted a parallel, superiority, 1:1 cluster-randomised controlled trial, randomly assigning LSP neighbourhoods and their inhabitants to either the intervention (N=560) or a waitlist control group (N=369), with 277 and 221 participants completing the baseline assessment, respectively. The intervention resulted in increases in physical activity after three months, with improvements in both moderate-to-vigorous (B=346.618 min/week, SE=141.185, p=0.014) and light-intensity (B=583.612 min/week, SE=180.736, p=0.001), although these effects diminished by six months. Loneliness, however, showed sustained reductions after three (B=-0.436, SE=0.229, p=0.058) and six months (B=-0.765, SE=0.237, p<0.001), highlighting the potential of a neighbourhood-oriented approach to reducing social isolation. No significant improvements were found in health-related quality of life, social cohesion, or digital engagement. These findings suggest that while neighbourhood-oriented interventions may effectively improve physical activity and reduce loneliness, further research and more targeted strategies are needed to enhance lasting improvements in physical activity and address broader health and well-being outcomes. This study emphasises the importance of considering the socio-environmental context in interventions and the need for ongoing support to maintain behavioural changes among older adults from lower socioeconomic backgrounds.

► **Perspectives of healthcare professionals on medical care in nursing homes in Germany and The Netherlands: an explorative study using qualitative content analysis**

FASSMER, A. M., GRENZ, A., ENNEN, M., *et al.*
2025

European Journal of Public Health 35(6): 1191-1197.
<https://doi.org/10.1093/eurpub/ckaf176>

The organization of healthcare for nursing home residents varies widely between systems, even between neighbouring countries such as Germany and the Netherlands. This study compares healthcare professionals' perspectives on strengths and challenges in medical care for nursing home residents in Germany and the Netherlands. Semistructured interviews were conducted in Germany with six nursing staff from six nursing homes and six general practitioners (GPs) in private practice and in the Netherlands with one elderly care physician (ECP) and seven nursing staff members from six nursing homes between August 2023 and March 2024. Interviews were audio recorded, transcribed, translated, and analysed using qualitative content analysis. Participants reported that Germany and the Netherlands face rising long-term care demands due to aging populations, however, their nursing home care models differ substantially. In Germany, care is reactive and fragmented, with external professionals, especially GPs, providing care. Challenges include delays, limited communication, and a lack of standardized processes. Conversely, the Netherlands adopts a structured, preventive approach, led by ECPs supported by multidisciplinary teams. This model emphasizes proactive monitoring, team collaboration, and holistic care but faces workload challenges and limited specialist access. Interprofessional collaboration is more hierarchical and record-based in Germany, while it is team-oriented and conversational in the Netherlands. This study highlights key differences in the organization of nursing home care in Germany and the Netherlands, particularly in access to specialists, interprofessional collaboration, and structures. Potential adaptations to improve care must fit within the existing structures of each healthcare system.

► **Different systems, same challenges: a comparative analysis of long-term care resilience in Norway, Finland, the Netherlands, Romania, Spain, Italy and Australia**

FELDER, M., BAL, R., REE, E., *et al.*
2026

Health Policy 163: 105484.
<https://doi.org/10.1016/j.healthpol.2025.105484>

Background Welfare states face multiple challenges in the sustainable organization of their long-term care (LTC) systems due to aging populations and structural workforce shortages. In this context, the need emerges to facilitate cross-country exchange of policy responses to strengthen LTC resilience. Objectives In this paper, we provide comparative insight into the LTC systems of Norway, Finland, the Netherlands, Romania, Spain, Italy, and Australia. We identify key challenges in organizing LTC in these systems and compare strategies implemented to enhance LTC resilience. Methods Our qualitative cross-country analysis is based on the Consolidated Framework for Implementation Research and adapted for LTC contexts. Data was derived from OECD databases and complemented with country specific publicly available data sources. Results We show that participating countries face similar workforce challenges and adopt comparable strategies such as aging-in-place policies, technological innovation, service integration, and task shifting. Subtle yet crucial differences can however be observed in the broader systemic conditions in place to support LTC employment, and in the trade-offs being made between care quality and accessibility. The differences highlight the crucial role of LTC organizations and particularly middle managers in translating workforce strategies into situated interventions that strengthen both organizational resilience and individual well-being. Conclusions To enhance LTC resilience in both the short and long term, translational challenges include strengthening the connections to informal carers; stabilizing ehealth technologies to support ageing-in-place; and balancing individual workers' ambitions and needs with organizational goals to keep healthcare accessible, responsive and of good quality.



► **Immigrant Staff in Nursing Homes: Mitigating Staffing Shortages During the COVID-19 Pandemic**

JUN, H., GENG, F., MCGARRY, B. E., *et al.*
2025

Medical Care Research and Review 82(6): 454–464.
<https://doi.org/10.1177/10775587251349064>

The COVID-19 pandemic exacerbated staffing shortages in U.S. nursing homes. Staff who are immigrants may have stronger tendencies to remain in their jobs than U.S.-born staff, but evidence is lacking. In this study, we predicted the share of immigrant ...

► **Un siècle de vieillissement en France, 1921-2021. Disparités de genre et de classe**

KESZTENBAUM, L.
2025

Travail, genre et sociétés n° 54(2): 25-43.
<https://doi.org/10.3917/tgs.054.0025>

L'arrivée aux grands âges des générations du « baby-boom » (nées après la fin de la Seconde Guerre mondiale) accélère depuis quelques années le vieillissement de la population française. Ce phénomène est profondément genré : non seulement les femmes représentent la très grande majorité des personnes âgées, mais leur part augmente fortement avec l'âge. Cet article présente ce processus de féminisation sur la longue durée et ce que son caractère massif invisibilise. À travers l'analyse de la condition des personnes vieillissantes depuis un siècle il met en évidence les très grandes disparités de genre dans l'expérience du grand âge, conséquence de pratiques et de structures de gestion de la vieillesse pensées autour d'un modèle orienté autour du travail masculin. Les femmes âgées sont plus souvent isolées, plus souvent pauvres, plus souvent en mauvaise santé.

► **Is Caring Productive? The Effect of Adult Social Care on Paid Production in England**

LONGO, F., CLAXTON, K., MASON, A., *et al.*
2025

Health Economics 34(12): 2182-2195.
<https://doi.org/10.1002/hec.70026>

ABSTRACT Long-term care (LTC) provides essential support to service users and informal carers to improve their quality of life. By improving quality of life, LTC can potentially impact economic growth, for exam-

ple, it may enable service users of working age and their carers to spend more time in paid employment. This study investigates the effect of publicly-funded LTC expenditure on a measure of paid production across local authorities in England. We analyze yearly data from 2014/15 to 2019/20 using a dynamic panel model estimated by the Arellano-Bond estimator. We find that a £1000 increase in LTC expenditure per client increases paid production per capita by £216 in the short run and by £670 in the long run. These findings may inform policy makers interested in assessing the financial sustainability of LTC policies.

► **Mortality risk factors in Catalonia's long-term care system: A population-based survival analysis**

PRADES-COLOMÉ, A.
2026

Health Policy 163: 105482.
<https://doi.org/10.1016/j.healthpol.2025.105482>

Background As populations age, understanding the health impact of long-term care Systems is critical for shaping effective policy. Objective This study investigates the association between long-term care benefits and mortality risk among older adults in Catalonia, Spain, using comprehensive administrative data from July 2015 to December 2024. Methods The analysis focuses on applicants of long-term care benefits in Catalonia aged 50+, categorizing them by severity of their needs (Grades I-III) and type of benefit received: home care, residential care, a combination of both or no benefit. It applies survival analysis techniques—including Kaplan-Meier estimators and Cox proportional hazards models. Results Individuals with long-term care needs receiving benefits have significantly lower mortality hazards. Notably, individuals transitioning from home to residential care exhibit the most favourable hazard ratios, suggesting that responsive care pathways are associated with better survival outcomes, potentially due to a most accurate matching of care to needs. Residential care alone is associated to higher mortality risk than home care in the population with the highest grades of long-term care needs. Individuals with recognized long-term care needs who do not receive any benefits face significantly higher risks. Mortality risk also varies by sex, age, and clinical profile, with higher hazards observed among men, older individuals, and those with previous haematological, neoplastic, or respiratory conditions. Conclusion These findings underscore the association between

formal long-term care systems and lower mortality risk and emphasize the importance of timely, adaptive care pathways in mitigating health decline among ageing populations.

► **Is home always the best place to live? Preferences for place of residence and long-term care among the community-dwelling oldest old in Finland**

PULKKI, J. M., AALTONEN, M. S., JYLHÄ, M. K., *et al.*
2025

European Journal of Public Health 35(6): 1198-1203.

<https://doi.org/10.1093/eurpub/ckaf196>

The aging in place policy emphasizes the older people's own desire to live at home. However, there is limited evidence on preferences for place of residence and long-term care, especially regarding the oldest old people. This study aims to fill this knowledge gap by identifying the preferences and associated factors of community-dwelling people aged 90+. Survey data, including a total age cohort of 90 years and older in one geographic area in Finland was analyzed descriptively and with multinomial logistic regression. The total study population was 1834 of which two-thirds were community-dwellers. Of the community-dwellers 71% preferred to live at their current homes, 18% preferred to live at their current homes if they received more help, and 11% would prefer to live in a residential care facility. Those who preferred to live at home had better functioning, rarely experienced dizziness, tiredness, loneliness, and pain, were more often satisfied with their life, and had better self-rated health compared to other preference groups. Preferences shifted gradually: the poorer the respondents' health, functional capacity, and well-being, the more likely they preferred to get more help at home or live in residential care. One-third of the respondents either preferred to have more help in their current home or to move to residential care, indicating that home was not the best place for them to live at that time. Findings suggest that the preferences for living at home are not stable but a dynamic process among the oldest old people.

► **Cognitive ageing: sex and life course social class differences in England**

RICHARDS, L., MAHARANI, A. ET PRÄG, P.
2026

Social Science & Medicine 388: 118787.

<https://doi.org/10.1016/j.socscimed.2025.118787>

Whilst cognitive decline is often assumed to be an inevitable part of old age, plenty of studies document its heterogeneity, with many older people showing high functioning and resilience to decline. Lower socioeconomic status is a known risk factor for cognitive decline. This study links the theoretical ideas of cognitive reserve to psychosocial theory and intersectionality to propose that combinations of demographic factors better define lived experiences of social position than individual categories for understanding patterns of cognitive function over time. We use 10 waves from the English Longitudinal Study of Ageing (ELSA), spanning 2002–2023, and operationalise cognitive ageing with repeated measures of episodic memory. We examine the intersectional effects of sex, birth cohort, own social class, and parents' social class using Multilevel Analysis of Individual Heterogeneity and Discriminatory Accuracy (MAIHDA) modelling. The results show women have better episodic memory scores than men, there is a gradient by social class, and parental social class exerts an influence on cognition over and above own class. The 'intersections' with the lowest cognition scores include those multiply disadvantaged, such as working-class women from lower-class backgrounds, and the downwardly mobile. Examination of pairs of interactions show that social class exerts stronger interactive effects than sex or cohort (having controlled for age). However, the variance components analysis from the model shows little evidence of significant intersectionality, and thus suggests that the effects of sex, birth cohort, own social class, and parents' social class are additive rather than multiplicative.

► **Long-Term Care at Advanced Ages: The Effect of Spousal Bereavement on Institutional Care Needs**

SCHOUWENAAR, C., KONING, P., KRABBE-
ALKEMADE, Y., *et al.*

2026

Health Economics 35(1): 118-134.

<https://doi.org/10.1002/hec.70043>

ABSTRACT With populations aging, long-term care (LTC) needs and costs rise, intensifying the reliance on informal care. Since spouses predominantly provide such care, it is crucial to understand the transition dynamics from widowhood to institutional LTC, which is the main driver of the public LTC costs in most OECD countries. Our study examines the causal effect of wid-

owhood on the onset of needs for institutional LTC. For this we use recently developed event-time models that accommodate for variation in treatment time and dynamic effects of treatment. Our results show that partner loss significantly increases the need for institutional LTC. The average effect of partner loss on the need for institutional LTC peaks at a 1.5 percentage point rise 3 months after widowhood and disappears after 10 months. The effect is strongest for individuals with psycho-geriatric disorders, the oldest old and the frail. Addressing the immediate need for institutional LTC after widowhood remains critical for effective aging-in-place strategies.

► **Influence of prior knowledge and experience on willingness to pay for home hospice services: a contingent valuation study**

STEIGENBERGER, C., LEITER, A. M., SIEBERT, U., *et al.*
2025

International Journal of Health Economics and Management 25(3): 293-315.

<https://doi.org/10.1007/s10754-025-09393-8>

Home hospice services contribute to dying in dignity by addressing medical and social needs at the end of life. The respective monetary valuation in a sense of willingness to pay is not available yet. We aim to quantify the benefits of home hospice services to society using society's monetary valuation and examine the influence of prior knowledge and experience on willingness to pay for home hospice services. A nationwide cross-sectional contingent valuation study was conducted in Austria. We analyzed the impact of the determinants of interest on having a positive willingness to pay for home hospice services via multivariate Probit regression. Stated willingness to pay was analyzed using interval regression. Variable selection of potential influence factors and confounders was based on the literature. The variables of interest, prior knowledge of and experience with home hospice services, were represented by twelve related variables. We included 1262 respondents in the analysis. The two-part regression analysis showed a statistically significant positive impact on the probability of having a positive willingness to pay by prior knowledge of home hospice services, prior donations, and the wish of not dying alone. Prior donations also increase the level of willingness to pay. The probability of a positive willingness to pay was statistically significantly lower for respondents that stated to have experienced the

death of more than ten close persons and perceived spending time with dying persons as burden than their respective counterparts. Our study provides evidence that information campaigns to increase the recognition and awareness of existing home hospice services could increase their perceived value in society.

► **Unequal care, unequal health care? Gender differences in health care use after adult care access**

WANG, W. ET COSTA-FONT, J.

2026

Social Science & Medicine 389: 118833.

<https://doi.org/10.1016/j.socscimed.2025.118833>

Access to care among older adults can reveal unmet health needs, though in some cases it may substitute for other forms of health care. We argue that the balance between these effects is largely gender dependent: female spouses are more likely to act as informal caregivers and, as a result, may have neglected their own health needs. To examine this issue, we exploit the variation introduced by Scotland's Free Personal Care (FPC) program, a government initiative implemented in 2002 that provides free personal care access to all eligible individuals regardless of income. Using a Difference-in-Differences (DiD) framework comparing Scotland with the rest of the United Kingdom and a rich longitudinal dataset of men and women aged 65 and over, we find that FPC significantly increased the uptake of home help services among women, with little change among men. Among women, this expansion in care access had a complementary effect, leading to a 3.5–percentage-point rise in inpatient admissions, whereas among men, the evidence suggests a modest substitution effect. The effects are strongest among older adults who live alone, face socioeconomic disadvantage, or have high care needs.

► **The Evolution of Long-Term Care and Health Policy in the United States**

WERNER, R. M., HOFFMAN, A. K. ET KONETZKA, R. T.

2025

Journal of Health Politics, Policy and Law 50(6): 1037-1058.

<https://doi.org/10.1215/03616878-11995144>

Long-term care policy has been neglected for decades in the United States because of high costs, leaving middle-class families struggling to afford care. Many rely

on unpaid caregivers, who face significant financial and emotional burdens. Historically, long-term care was a family or community responsibility, but in 1965, with the creation of Medicare and Medicaid, Medicaid became the default payer for long-term care. However, Medicaid only supports low-income individuals and does so incompletely. Medicare pays for long-term care only incidentally and temporarily by providing postacute care in nursing homes and at home. Private insurance is rare because of affordability and policy constraints. Unpaid caregivers fill in the gaps. While the system has evolved over time, most notably shifting from institutional settings to home-based settings, significant gaps remain. The result is a fragmented system that does not work well for most people. It is possible to reform long-term care through options including expanding Medicaid coverage, incorporating long-term care into Medicare, or creating a new social insurance program. Each option requires significant government funding and political commitment. Without action, the current system will continue to fail aging individuals and their families.

Index des auteurs Author index

A

Aaltonen, M. S.	72
Abushanab, D.	16
Abu, T. Z.	20
Achalid, G.	44
Achore, M.	20
Ademi, Z.	16
Adrien, V.	45
Ahtiluoto, S. E.	22
Alayo, I.	23
Alfò, M.	23
Alizadeh, A. H.	54
Alla, F.	40
Allaudeen, N.	42
Allen, H.	39
Allin, S.	19, 64
Anderson, K. M.	54
Andrews, A.	30
Antonini, M.	42
Aquines, A. G.	60
Armitage, C. J.	58
Arnold, M. L.	13
Arpin, E.	39
Arvez, M. J. A.	16
Ashrafian, H.	59
Ashton, R. E.	40
Avdic, D.	14
Azadi, B.	51

B

Badache, A. C.	67
Balbolia, S.	43
Bal, R.	70
Barber, S. L.	67
Barbet, A.	43
Barnay, T.	26
Baslock, D.	45
Becker, K.	30
Beckett, M. K.	27
Béliard, A.	68
Ben Jelili, E.	39
Benquet, M.	68
Berete, F.	66

Bergvall, S.	45
Blum, P.	68
Bodin, J.	66
Bolman, C. A. W.	69
Bond, K.	41
Bondoux, J.	26
Borrell, L. N.	54
Bortnowschi, M.	29
Botha, F.	65
Bouaziz, L.	45
Bouille, R.	43
Bränström, R.	49
Breivik, H.	31
Breton, P.	21
Brewster, L.	25
Bueno, H.	46
Bundgaard, M.	61
Bureau, V.	59
Burgio, A.	54
Butsch, C.	30
Byng, R.	51

C

Cacicedo, J.	23
Cambon, L.	40
Canaud, M. C.	63
Carpen, T. P.	22
Chabot, T.	68
Chekar, C. K.	25
Chen, L.	26
Chéron, G.	27
Chilman, N.	31
Chopard, B.	14
Cirillo, C.	22
Clavel, N.	21
Claxton, K.	71
Cohea, C. W.	27
Copello, F.	27
Costa-Font, J.	73
Crainich, D.	16
Crandall-Nickolet, A. B.	34
Cuomo, M.	54
Czymoniewicz-Klippel, M. T.	25
Czypionka, T.	20

D

Das-Munshi, J.	47
Dattaro, M.	27
Deaton, C.	46
De Brabandere, L.	69
De Clercq, B.,	66
De Montgomery, C. J.	31
Descamps, E.	44
Detering, B.	36
de Vries, E. F.	18
Diel, M.	55
Dillender, M.	18
Dobrosavljevic, M.	67
Donnelly, R.	46
Dos Santos, S.	48
Dros, J. T.	17
Duggan, C. E.	17
Duijsens, L. J. E.	69
Dukers-Muijrs, N.	43
Duraccio, R.	22

E

Eckels, K.	41
Edwards-Smith, L.	51
Elma, A.	55
Elodie, R.	32
Ennen, M.	70
Espinosa, O.	17
Essue, B. M.	19

F

Farina, M. P.	46
Farrero, M.	46
Fassmer, A. M.	70
Fattori, S.	23
Favré, P.	48
Felder, M.	70
Fernström, C.	45
Figueroa, J. F.	17
Fontana, S.	32
Forbes, L.	59
Fordellone, M.	22
Forsius, P. T.	22
Forthun, I.	31
Fourel, E.	48

Frederick, D.	48
Fredslund, E. K.	61
Frost, R.	43

G

Gabellone, V.	15
Galharret, Y.	56
Garcia, S.	56
Garrouste, C.	43
Gastaldi, L.	16
Gautier, L.	64
Gelly, M.	56
Gémes, K.	65
Geng, F.	71
Gilliam, K.	14
Ginneken, D. E. V.	56
Gomes, B.	41
Gorasso, V.	35
Gorostiza, A.	23
Gosling, J.	40
Grenz, A.	70
Grobbee, D. E.	38
Grytten, J.	32
Gschwent, L.	18
Guccio, C.	32
Günaydin, G. P.	15
Guo, X.	65

H

Haesebaert, J.	23
Hamelin, C.	56
Hammarfelt, B.	18
Hamroun, A.	33
Hanlon, H. R.	57
Harris, K.	38
Hayes, J.	51
Haynes, D.	14
Hiilamo, A.	33
Hoffman, A. K.	73
Horny, M.	18
Howard, D. H.	18
Howard, H.	64
Hsu, S. C.	21
Huang, Q.	34
Huang, X.	18
Huberman, D. B.	42
Hu, H.	67

Humphries, N.	57
Hunter, R. M.	43
Hunter, S.	34
Huntington, A.	50

I

Idavain, J.	35
Irvine, N.	63

J

Jacobs, E.	40
Jacques, O.	39
Johnson, J.	58
Jona Lasinio, G.	23
Jones, A. M.	13
Josefsson, P.	65
Joynt Maddox, K. E.	17
Judith, M. F.	32
Juet, A.	43
Jun, H.	71
Jusot, F.	26
Jylhä, M. K.	72

K

Kabátek, J.	65
Kakani, P.	57
Kalwarowsky, S.	43
Karlsson, M.	18
Kelly, E.	57
Keskimäki, I.	58
Kesztenbaum, L.	71
Keyworth, C.	58
Kietzman, K.	26
Kihlström, L.	58
Kim, D.	13, 46
Kimpton, S.	30
Kirchner, S.	65
Kivits, J.	51
Klootwijk, A.	18
Knobé, S.	51
Knudsen, A. K. S.	31
Konetzka, R. T.	73
Koning, P.	72
Kovacevic, L.	59
Kowal, S.	19

Kraas, F.	30
Krabbe-Alkemade, Y.	72
Krawczyk, N.	47
Kuhlmann, E.	59
Kunz, J. S.	14

L

Ladegaard Knox, J. B.	53
Lafortune, G.	63
Lambert, M.	25
Laporte, D.	31
Last, B. S.	59
Le, E.	42
Lefèvre, L.	51
Leila, R.	32
Leiter, A. M.	73
Lemarchant, C.	68
Leporatti, L.	27
Le Roux, G.	68
Lescher-Cluzel, M.	21
Leslie, T. F.	48
Les Tribunes de la santé.	64
Li, H.	67
Li, N.	43
Longo, F.	71
Lotta, G.	59

M

Mackinnon, S.	35
Maharani, A.	72
Majda, T.	19
Major, M. E.	66
Maléfant, L.	25
Malenica, I.	13
Mallard, S.	47
Manoukian, S.	63
Manuel, J. I.	45
Marques, M. M.	62
Marraud, L.	21
Marsano, F.	15
Mason, A.	71
Mason, H.	63
Matsuo, Y.	36
Mattsson, M.	37
Mauri, A. I.	48
McGarry, B. E.	71
McGowan, V. J.	34

McVey, L.	60
Meacock, R.	61
Mearns, E. S.	19
Meekes, J.	65
Melegaro, A.	42
Menard, L.	39
Méndez, S. J.	14
Mesiano, N.	60
Meyers, D. J.	13
Michalska, K.	60
Milcent, C.	28
Mitchell, E.	50
Mogin, G.	35
Moreno-Agostino, D.	47
Morize, N.	63
Morvan, G.	66
Moscone, F.	28
Mouchabac, S.	47
Mousquès, J.	56
Mullaputi, P. S. P.	52
Müller, C.	55
Munford, L.	38
Murray, R. C.	29
Musy, O.	14
Muyingo, L.	35

N

Nguyen, A. Q.	44
Nguyen, H. T.	44
Nguyen, N. T.	44
Nguyen, K. H.	13, 39
Nguyen, T. T.	52
Niang, A. T.	33
Ninot, G.	44
Nuccetelli, F.	15

O

Oberlander, J.	39
O'Callaghan, M.	57
Occelli, F.	33
Ökem, Z. G.	15
Olivella, P.	19
Olive, M. V.	16
Öntaş, E.	60
Onvlee, O.	40
Orival, T.	51
Orus-Covisa, L.	29

Özel, B. A.	15
------------------	----

P

Pachankis, J. E.	49
Palau-Costafreda, R.	29
Parkinson, B.	61
Pedersen, L. B.	61
Peels, D. A.	69
Peng, L.	65
Phillips, S.	13
Pignataro, G.	32
Ploubidis, G. B.	47
Pontonnier, A. L.	37
Prades-Colomé, A.	71
Präg, P.	72
Proaño, D.	19
Propper, C.	57
Pulkki, J. M.	72
Purtle, J.	48

R

Radaelli, G.	16
Rai, U.	34
Rambod, B.	43
Ranehill, E.	45
Rast, E.	36
Ree, E.	70
Reifegerste, D.	49
Remes, H. M.	24
Renard, V.	62
Richards, L.	72
Ridde, V.	40
Rijken, D.	56
Robicquet, P.	52
Rodino, I.	53
Rodriguez, J.	17
Rodriguez-Lesmes, P.	17
Roelandt, J.	25
Rohleder, S.	36
Rolland, B.	23
Romanello, M.	21
Rossigneux-Méheust, M.	68
Rowland, R.	50
Ryan, A. M.	29

S

Saliba, D.	27
Samples, H.	47
Samson, A. L.	43
Sandoe, E.	64
Santos, R.	60
Sato, S.	36
Saur, R.	48
Sauzet, O.	24
Schäfer, M.	24
Schantz, C.	53
Scherr, S.	49
Schofield, P.	31
Scholes, A. K.	55
Schouwenaar, C.	72
Schuurmans, J.	69
Schwoerer, M.	48
Shabaan, A. N.	37
Shadili, G.	48
Shah, V.	13
Sherry, S. B.	35
Siciliani, L.	63
Siebert, U.	73
Silva, C. C.	62
Simons, M.	25
Singer, A.	55
Singh, R.	42
Skau, I.	32
Smart, B. D.	49
Spencer, J.	29
Spishak-Thomas, A.	64
Stanhope, V.	45
Stegner, C.	20
Steigenberger, C.	73
Struckmann, D. V.	56
Suneson, I.	50
Sutton, M.	61
Suulamo, U. K.	24
Sweeney, N. P.	36

T

Taha, A.	62
Tarkiainen, L. H.	24
Ternay, J.	23
Thébault, J. L.	62
Thomas, C.	40
Thorpe, L.	54
Tjosvold, L.	41

Todd, A.	38
Tonti, L.	13
Tosetti, E.	28
Tran, P. B.	66
Tromp, N.	40

U

Unuia, T. J.	30
Urrini, M.	53
Usher, S.	64

V

Valenti, R.	53
Vallet, B.	21
Van Allen, Z.	62
Van de Beek, S. H.	41
Van Der Velde, L.	37
Van der Woerd, O.	69
Van Dijk, C. E.	17
Vera-Hernández, M.	19
Verheij, R. A.	17
Vicente-Castellví, E.	29
Videau, Y.	56
Vieira, L.	37
Viita-aho, M.	58
Vittadini, G.	28
Vrangbæk, K.	31

W

Wagner, A.	49
Walawender, M.	21
Wang, W.	73
Ward, R.	29
Warkentin, L. M.	41
Weber, C. E.	55
Wedlow, M.	14
Werner, R. M.	73
Whaley, C. M.	29

X

Xu, Z.	34
-------------	----

Y

Yahiatene, L.	53
Yasunaga, H.	36
Yavuz, C. I.	60
Youssef, D. M.	38
Yue, X.	52

Z

Zaranko, B.	57
Zhou, J.	34
Zhu, J. M.	50 , 59
Zied Abozied, E.	38
Zong, X.	67