Institut de recherche et documentation en économie de la santé
Institute for Research and Information in Health Economics

Veille scientifique
en économie de la santé

Watch on Health Economics Literature

Juillet-Août 2025 / July-August 2025

Assurance maladie	*Health Insurance*
Démographie	*Demography*
E-Santé – Technologies médicales	*E-health – Medical Technologies*
Économie de la santé	*Health Economics*
Environnement et santé	*Environmental Health*
État de santé	*Health Status*
Géographie de la santé	*Geography of Health*
Handicap	*Disability*
Hôpital	*Hospital*
Inégalités de santé	*Health Inequalities*
Médicaments	*Pharmaceuticals*
Méthodologie – Statistique	*Methodology - Statistics*
Politique de santé	*Health Policy*
Politique social	*Social policy*
Prévention	*Prevention*
Psychiatrie	*Psychiatry*
Soins de santé primaires	*Primary Health care*
Sociologie de la santé	*Sociology of Health*
Systèmes de santé	*Health Systems*
Travail et santé	*Occupational Health*
Vieillissement	*Ageing*

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Veille scientifique en économie de la santé

Watch on Health Economics Literature

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Sommaire
Contents

Assurance maladie
Health Insurance

Démographie
Demography

E-santé – Technologies médicales
E-Health- Medical Technologies

Economie de la santé
Health Economics

Environnement et santé
Environmental Health

État de santé
Health Status

Géographie de la santé
Géographie of Health

Handicap
Disability

Hôpital
Hospital

Inégalités de santé
Health Inequalities

Médicaments
Pharmaceuticals

Méthodologie – Statistique
Methodology – Statistics

Politique de santé
Health Policy

Politique sociale
Social Policy

Prévention
Prevention

Psychiatrie
Psychiatry

Sociologie de la santé
Sociology of Health

Soins de santé primaire
Primary Healthcare

Systèmes de santé
Health Systems

Travail et santé
Occupational Health

Vieillissement
Ageing

Assurance maladie

Health Insurance

Does Medicaid Improve Health?

ALLEN, H.

2025

American Journal of Public Health 115(6): 833-834.

https://doi.org/10.2105/AJPH.2025.308124

This perennial policy question has resurfaced, particularly after the US House of Representatives recently passed a budget blueprint tasking the committee overseeing Medicaid and Medicare with cutting $880 billion over the next 10 years. This issue was also a focal point during state deliberations on whether to adopt Medicaid expansions under the Affordable Care Act (ACA). Since the ACA's passage in 2015, 40 states and the District of Columbia have expanded Medicaid, with a few adopting it through citizen ballot initiatives, while 10 states have not.2 Because of the staggered implementation of Medicaid expansion, Medicaid is far more studied than other forms of coverage. Whether this focus is fair or not is debatable,3 but Medicaid skeptics often cite research my colleagues and I conducted 15 years ago—the Oregon Health Insurance Experiment (OHIE)—as evidence against expansion. More recently, some have used this research to justify targeting Medicaid spending4 to offset the continuation of the 2017 tax cuts, which disproportionately benefit higher-income Americans.

The ethics of behaviour-based insurance models: Solidarity-based concerns in Germany's statutory health insurance

BREDTHAUER, C. J., KUHN, E. ET BUYX, A.

2025

Health Policy 156: 105318.

https://doi.org/10.1016/j.healthpol.2025.105318

Sickness funds have begun to harness digital behavioural data to incentivise physical activity in their members. This ethical and societal effects of this phenomenon remain largely unclear, especially in solidarity-based insurance systems. Therefore, this study analysed the risks and benefits of such programmes with respect to solidarity against the background of recent efforts by German statutory health insurance funds to integrate digital tracking data into their bonus programmes. Key, potential benefits include new forms of solidarity that may emerge based on sharing personal health data. The incentives introduced by these reward programmes could lead to efficiency gains used to benefit society. However, three conceptual pitfalls have been identified: First, the data gathering method may penalise certain vulnerable groups. Such discrimination could, however, be avoided by minimising barriers to participation. Second, digitally mediated bonus programmes may create deadweight effects, i.e. beneficiaries are likely to already be healthy and active. Consequently, behavioural targets should be designed to consider individual prerequisites. Lastly, linking premiums to behaviour might diminish solidarity with poor risks within statutory health insurances and between statutory and private health insurance. Hence, this study aimed to stimulate debate on the ethical and societal implications of the systemic integration of eHealth innovations into healthcare systems.

Medicare at 60: Suggestions for balancing access to care and financial protections with fiscal concerns

CHERNEW, M. E. ET MASI, P. B.

2025

Health Services Research 60 Suppl 2(Suppl 2): e11415.

https://doi.org/10.1111/1475-6773.14415

The impact of a payer-provider joint venture on healthcare value

GARABEDIAN, L. F., WHARAM, J. F., NEWHOUSE, J. P., *et al.*

2025

Health Serv Res 60(3): e14400.

https://doi.org/10.1111/1475-6773.14400

OBJECTIVE: To examine how a novel payer-provider joint venture (JV) between one payer and multiple competitive delivery systems in New Hampshire (NH), which included value-based payment, care management, and non-financial supports, impacted healthcare value and payer and provider group experiences. STUDY SETTING AND DESIGN: We conducted a mixed-methods study. We used a quasi-experimental longitudinal difference-in-differences design to examine the impact of the JV (which started in January 2016 and ended in December 2020) on healthcare utilization, quality, and spending, using members in Maine (ME) as a control group. We also analyzed patient uptake of the JV's care management program using routinely collected administrative data and assessed payer and provider group leaders' perspectives about the JV via semi-structured interviews. DATA SOURCES AND ANALYTIC SAMPLE: We used administrative and claims data from 2013 to 2019 in a commercially insured population under 65 years in NH and ME. We also used administrative data on care management eligibility and uptake and conducted semi-structured interviews with payer and provider group leaders affiliated with the JV. PRINCIPAL FINDINGS: The JV was associated with no sustained change in medical utilization, quality, and spending throughout the study period. In the first year of the JV, there was a $142 (95% confidence interval: $41, $243) increase in pharmaceutical spending per member and a 13% (4.4%, 25%) relative increase in days covered for diabetes medications. Only 15% of eligible members engaged in care management, which was a key component of the JV's multi-pronged approach. In a disconnect from the empirical findings, payer and provider group leaders believed that the JV reduced healthcare costs and improved quality. CONCLUSIONS: Our findings provide evidence for future payer-provider JVs and demonstrate the importance of having a valid control group when evaluating JVs and value-based payment arrangements.

Medicaid Expansion and US Mortality Rates During the COVID-19 Pandemic, 2018–2022

HAN, X., SHI, K. S., FAN, Q., *et al.*

2025

American Journal of Public Health 115(6): 890-899.

https://doi.org/10.2105/ajph.2025.308045

Objectives. To examine the association of state Medicaid expansion status with mortality changes during the COVID-19 pandemic in the United States. Methods. Deaths among individuals 20 to 64 years of age in 3142 counties were identified from 2018 to 2022 mortality surveillance data. Age-adjusted mortality rates were calculated for each county and by cause of death. Changes in mortality rates before and after the onset of the COVID-19 pandemic (2018–2019 vs 2021–2022) in Medicaid expansion states relative to non expansion states were calculated after adjustment for county sociodemographic factors and state COVID-19 vaccination rates. Results. All-cause mortality rates increased in 2020–2021 nationwide and decreased slightly in 2022. Overall, the increase was slower in Medicaid expansion states, leading to a net decrease of 31.8 (95% confidence interval [CI] = 20.9, 42.8) deaths per 100 000 person-years associated with Medicaid expansion from 2018–2019 to 2021–2022. The decrease was largest for deaths from heart disease and liver disease and was observed across subpopulations stratified by sex, age, and race. Conclusions. Increases in mortality rates were slower in Medicaid expansion states than in non expansion states during the COVID-19 public health emergency, suggesting a protective effect of Medicaid expansion on population health during the pandemic. (Am J Public Health. 2025;115(6):890–899. https://doi.org/10.2105/AJPH.2025.308045)

Enrollment in Medicare is associated with fewer outpatient mental healthcare visits among those with mental health symptoms

MCCORMACK, G., DUFFY, E., ROHRER, J., *et al.*

2025

Health Services Research 60 Suppl 2(Suppl 2): e14423.

https://doi.org/10.1111/1475-6773.14423

Abstract Objective To test whether enrolling in traditional Medicare (TM) or Medicare Advantage (MA) at age 65 reduces mental healthcare utilization among individuals with mental health symptoms and low or moderate family incomes. Study Setting and Design We employ a fuzzy regression discontinuity design, comparing the likelihood of having an outpatient mental health visit or a psychotropic drug fill among individuals younger than or older than the age 65 Medicare eligibility threshold. Data Sources and Analytic Sample We analyze 2014–2021 Medical Expenditure Panel Survey data. Our primary sample is restricted to individuals with probable mental health symptoms as indicated by their score on the Kessler K6 psychological distress scale (K6) and Patient Health Questionnaire-2 instrument (PHQ-2) and who have incomes less than 400% of the federal poverty level. Principal Findings Among individuals with probable mental health symptoms and low or moderate incomes, enrolling in Medicare (combining the effect of MA and TM) is associated with a 24.9 percentage point reduction (95% CI −49.1 to −0.8; p = 0.043) in the likelihood of having any type of outpatient mental health visit and a 31.3 percentage point reduction (95% CI –54.2 to –8.4; p = 0.008) in the likelihood of having a prescription drug fill for a psychotropic drug. Effects of MA and TM on mental healthcare utilization are not statistically different from each other. We observe no impact of enrolling in Medicare on the likelihood of having a visit to a primary care provider, having a visit to a non-mental healthcare specialist, or having a fill for a prescribed non-psychotropic drug. Conclusions Enrolling in Medicare is associated with a reduction in the use of mental healthcare among individuals with probable mental health symptoms and low or moderate family incomes. Our findings suggest that the program poses access barriers specific to mental healthcare.

▶ Out-Of-Network Utilization and Plan Selection Among Medicare Advantage Cost Plan Enrollees

MCCORMACK, G. ET TRISH, E.

2025

Health Serv Res 60 Suppl 2(Suppl 2): e14438.

https://doi.org/10.1111/1475-6773.14438

OBJECTIVE: To understand how Medicare Advantage (MA) networks impact utilization patterns and plan choices, using the 2019 discontinuation of MA 1876 Cost plans as a natural experiment. STUDY SETTING AND DESIGN: We study 1876 Cost plans, MA plans for which out-of-network care is covered through traditional Medicare (TM) and many of which CMS discontinued in 2019. We characterize the proportion of Cost plan enrollees who utilized out-of-network care in 2018 from different types of medical specialties. We then study how enrollees in discontinued plans selected into new plans in 2019. We use regression analysis to characterize whether higher risk enrollees selected into TM at higher rates. DATA SOURCES AND ANALYTIC SAMPLE: We identify discontinued plans using public MA plan data. We employ administrative Medicare enrollment and TM claims data to identify 2018 enrollees of discontinued plans, their 2018 out-of-network utilization, and their subsequent 2019 enrollment decisions. PRINCIPAL FINDINGS: Among Cost plan enrollees, 69% utilized non-emergency room related care out of network in 2018. Out-of-network utilization was distributed across several types of specialties: 43% of Cost plan enrollees had at least one out-of-network claim with a primary care physician and over 20% had a claim with a medical specialist, surgical specialist, or nurse practitioner. We find evidence of adverse selection among enrollees of discontinued Cost plans in 2019. Conditional on one's 2018 Cost plan and county of residence, a standard deviation increase in risk score was on average associated with a 26.35% (95% CI, 25.57%-27.12%) increased likelihood of enrolling in TM. CONCLUSION: The high rate of out-of-network utilization suggests that MA enrollees value access to care outside of standard MA networks. Subsequent selection patterns indicate that preferences for broader networks and subsequent enrollment in TM is highest among higher risk enrollees, suggesting limited networks may induce extensive margin selection.

▶ Common institutional ownership and the erosion of competition in the American health insurance market: A quantitative analysis

SMITH, K.

2025

Health Policy 156: 105316.

https://doi.org/10.1016/j.healthpol.2025.105316

Background Empirical studies have shown that when large institutional investors and private equity funds own a significant stake in multiple publicly traded firms within an industry, this common ownership may lead to anti-competitive behavior. In 2010, the Affordable Care Act (ACA) was passed. This law created health insurance exchanges that allowed for Americans to purchase health insurance plans directly on a marketplace. The insurers on this marketplace have common institutional owners, that could influence the level of competition in these markets. Objective To assess the causal effects of common ownership on competition in the US health insurance market. Methods To identify the causal impact of common ownership, I use two empirical strategies: the Arellano-Bond Dynamic Panel Model and Bartik-style Instruments. Data on firm ownership came the paper, “Common Ownership Data: Scraped SEC form 13F filings for 1999-2017” by Matthew Backus, Christopher Conlon, and Michael Sinkinson. Results The results show that a one standard deviation increase in common ownership leads to a 7.7 % increase in monthly premiums charged for certain health insurance plans. This finding is robust to different model specifications and suggests that common ownership reduces competition in the health insurance exchanges. Conclusions The results from this paper indicate that policymakers and regulators need to formulate policies that limit the amount that institutional investors and private equity funds can own of companies in the health insurance industry in the US. Additionally, policymakers need to make more data on firm ownership available, as the data that is available has quality issues.

Examining Trends in Medicare Advantage Plan Disenrollment Associated With Expanded Supplemental Benefit Adoption

TUCHER, E. L., MEYERS, D. J., TRIVEDI, A. N., *et al.*

2025

Health Services Research 60 Suppl 3(Suppl 3): e14460.

https://doi.org/10.1111/1475-6773.14460

ABSTRACT Objective To evaluate the association between Medicare Advantage (MA) supplemental benefit adoption and plan disenrollment among plans that adopted either the 2019 nonmedical primarily health-related benefits (PHRB) or the 2020 social needs Special Supplemental Benefits for the Chronically Ill (SSBCIs). Study Setting and Design We linked individual-level Medicare administrative data to publicly available, plan-level MA benefit, enrollment, crosswalk, and penetration files from 2017 to 2021. The PHRB benefits included benefits such as caregiver support, adult day care, in-home support services, and so forth. The SSBCI benefits included benefits such as food and produce, nonmedical transportation, pest control, and so forth. We used a difference-in-differences design studying MA enrollees stratified by Medicare-Medicaid dual eligibility status. Data Sources and Analytic Sample We included individuals from across the 50 United States and DC enrolled in MA plans that adopted a PHRB in 2019 or SSBCI in 2020 and matched comparator plans from the same counties that did not adopt either benefit. Individuals were excluded if they moved, died, or lacked county-level information during the year. Principal Findings Our sample includes 8,947,810 unique MA enrollees (27.4% in plans that adopted a PHRB and 1.0% in plans that adopted an SSBCI). For dual-eligible enrollees, neither PHRB adoption (0.2%, 95% CI, −2.7%, 2.8%) nor SSBCI adoption (−1.7%, 95% CI, −6.0%, 2.5%) was significantly associated with the rate of plan disenrollment. For Medicare-only enrollees, neither PHRB adoption (−2.6%, 95% CI, −5.9%, 0.7%) nor SSBCI adoption (−5.4%, 95% CI, −15.8%, 5.1%) was significantly associated with the disenrollment rate. Conclusion The promise of these benefits was that MA plans could more directly address enrollees' nonmedical and social needs, leading to better social and health outcomes and reducing costs. We find that adoption did not decrease plan disenrollment, which suggests it may not drive enrollment decisions.

Démographie

Demography

La population de la France va-t-elle diminuer ?

TOULEMON, L. ET PISON, G.

2025

Population & Sociétés n° 631(3)

https://doi.org/10.3917/popsoc.631.0001

La croissance de 0,25 % de la population de la France en 2024 tient pour les neuf dixièmes au solde migratoire et pour un dixième au solde naturel. La baisse de ce dernier vient à la fois d'une diminution des naissances et d'une hausse des décès. Sous l'hypothèse d'une fécondité et d'un solde migratoire stables aux niveaux de 2024, ainsi que d'une hausse de l'espérance de vie à un rythme ralenti, la projection indique que le solde naturel deviendrait négatif en 2027 mais que la population augmenterait encore pendant deux décennies.

E-santé – Technologies médicales

E-Health- Medical Technologies

Impacts of Hospital Data Breach on Healthcare Quality

CHEN, D., CHOU, S. Y. ET PENG, X. D.

2025

Health Services Research 60(3): e14439.

https://doi.org/10.1111/1475-6773.14439

ABSTRACT Objective To examine the effects of data breach incidents on healthcare quality and to explore potential mechanisms. Data Source Hospital-level data breach reports from the U.S. Department of Health and Human Services and patient-level hospitalization records from Florida State Inpatient Database during 2013–2017. Study Design We employ a propensity score matching difference-in-difference model to estimate changes in a patient's emergency department (ED) door-to-hospital admission hours, days to undergo principal procedure after admission, length of stay days, and in-hospital mortality rates following data breaches. We compare the health information technology (HIT) functionalities of breached and non-breached hospitals during both pre and post periods. Data Collection/Extraction Methods Our primary analysis covers 1,295,537 records of inpatients admitted through the EDs of 12 hospitals. Principal Findings Data breaches are associated with long-term improvements in healthcare quality, particularly in the timeliness of patient care and acute myocardial infarction (AMI) mortality. Over time, patients experience a reduction of 0.56 h in ED door-to-hospital admission time (95% confidence interval [CI]: −1.04 to −0.06 h) and a decrease of 0.18 days in time to undergo the principal procedure after hospital admission (95% CI: −0.23 to −0.13 days). Additionally, AMI patients experience a one percentage point reduction in in-hospital mortality (95% CI: −2 to −0.06 percentage points), while mortality rates for other patient groups remain unchanged. Hospitals affected by data breaches show long-term advancements in their HIT functionalities. Conclusions Hospital data breach incidents are associated with improved healthcare quality. This improvement may be attributed to hospitals' enhanced functionality of HIT.

Identification of Social Risk-Related Referrals in Discrete Primary Care Electronic Health Record Data: Lessons Learned From a Novel Methodology

DANKOVCHIK, J., GOLD, R., OCHOA, A., *et al.*

2025

Health Services Research 60 Suppl 3: e14443.

https://doi.org/10.1111/1475-6773.14443

ABSTRACT Objective To assess the utility of using discrete primary care electronic health record (EHR) data to identify social risk referrals in a national network of community-based clinics. Data Sources and Study Setting Primary data were abstracted from the OCHIN network EHR (June 2016 to February 2022) of 1459 community-based clinics across the United States. Study Design Structured data elements included 913 commonly used smartphrases and 53 procedure codes that were considered potential indicators of social risk referrals. Using stratified purposive sampling, we compared these discrete data with clinical notes to assess concordance of social risk referral documentation, and of the prevalence, types, and outcomes of such referrals. Data Collection/Extraction Methods Smartphrases were classified into three categories (likely, possible, or unlikely to indicate a social risk referral); 50 chart notes were sampled for each of the 25 most frequently used smartphrases in each category, and for 53 of the most frequently used procedure codes. A total of 6104 chart notes were reviewed. Principal Findings In 59% of chart notes where discrete data suggested a social risk referral occurred, there was no documentation of this in the note. Primary domains addressed were food insecurity (38%), financial stress (18%) and housing needs (18%). Common referral activities included providing contact information (26%), help with assistance applications (17%), and direct provision of resources (16%). Documentation indicated the patient received resources in 29% of notes. Conclusions EHR documentation of social risk referrals in structured data fields is inconsistent. Further work should establish best practices, especially given emerging policies that tie payments to documentation of social risk screening and intervention provision. Community health centers may struggle to use data elements such as smartphrases and procedure codes to monitor and report on their social risk referrals until standardized coding practices are established and effectively implemented.

Prise en charge actuelle de l’insuffisance cardiaque : outils connectés, télésurveillance et réseaux de soins

DE GROOTE, P.

2025

Bulletin de l’Académie Nationale de Médecine 209(5): 710-717.

https://doi.org/10.1016/j.banm.2025.03.001

Résumé Éducation thérapeutique, réseaux de soins et télésurveillance font partie de l’arsenal thérapeutique de l’insuffisance cardiaque (IC). L’éducation thérapeutique a débuté dans les années 1990, rapidement intégrée aux réseaux de soins, qui se sont modernisés ces dernières années avec le développement des outils connectés de surveillance. En France, la télésurveillance est remboursée depuis 2023 par l’Assurance maladie. Cette prise en charge non médicamenteuse repose sur un paradoxe. La majorité des équipes spécialisées dans l’IC est persuadée que cette prise en charge est efficace malgré une démonstration scientifique insuffisante. Les résultats contradictoires des études peuvent s’expliquer par la grande difficulté à les concevoir (étude ouverte, prise en charge variable des patients par les centres, technologies de surveillance différentes, sévérité des patients…). Dans le futur, l’évolution de la technologie permettra sans doute d’améliorer l’interprétation des informations recueillies par les outils de télésurveillance.

Enhancing Health Care Access and Quality through Remote Patient Monitoring: Insights from a Field Study in the United States

MILLET, L.

2024

Journal de gestion et d’économie de la santé N° 4(4): 35-55.

L’adoption de la télésurveillance médicale (TLS) dans les systèmes de santé transforme progressivement l’organisation des soins en permettant un suivi continu des données de santé des patients en dehors des structures cliniques traditionnelles. La TLS favorise une prise en charge proactive des maladies chroniques et répond à des besoins de soins complexes. Grâce à l’utilisation de dispositifs connectés, elle renforce l’autonomie des patients, réduit les barrières d’accès aux soins et limite les risques liés aux consultations en présentiel, un avantage particulièrement mis en évidence pendant la pandémie de COVID-19. Malgré son potentiel transformateur, l’intégration de la TLS dans les pratiques de soins courantes soulève des défis majeurs, notamment son articulation avec les modèles de soins existants, son adoption par les patients, l’adaptation des équipes soignantes, ainsi que la viabilité financière et opérationnelle de son déploiement. Cette étude analyse la mise en œuvre et l’opérationnalisation de la TLS au sein de NYU Langone Health, un centre médical universitaire de premier plan aux Etats-Unis, entre août 2023 et août 2024. Réalisée dans le cadre du Harkness Fellowship in Healthcare Policy and Practice, l’étude a été conduite au sein du HiBRID Lab de NYU Langone Health et du Bipartisan Policy Center à Washington, D.C. À travers une approche qualitative combinant entretiens avec les parties prenantes, observations de terrain et revue de littérature, cette étude explore les facteurs clés influençant l’efficacité, l’adoption et l’intégration durable de la TLS dans les systèmes de santé.

From clicks to care: Exploring the digital strategies of Italian health authorities in communicating "General Practitioner Selection" service

VINCI, A., PIRROTTA, L., VENTURI, G., *et al.*

2025

Health Policy 157: 105347.

https://doi.org/10.1016/j.healthpol.2025.105347

The prioritization of digitalization is crucial to the agendas of nations worldwide. While substantial funds have been allocated to foster it, there remains a scarcity of tools dedicated to systematically monitoring the performance of the digital transformation. This work describes the level of digitalization and information of a fundamental primary care service: the “General Practitioner (GP) selection”. The analysis was conducted by consulting websites of Italian Local Health Authorities (LHAs). First, we explored the digitalization levels of 105 websites through the Primary Care Digital Information (PCDI) composite index. It comprises four dimensions: informativeness, accessibility, inclusiveness, and adaptability, scoring on a five-point scale (low-high digitalization). Second, we conducted a readability analysis, employing three validated measures. We found an average level of digitalization and information, although dimensions perform differently. The best-performing dimension was adaptability, while the worst was inclusiveness. Half of the LHAs provided several digital alternatives to GP selection, while the remaining provided limited or no options. Regarding readability, just 29% of the LHA's websites were found easy to read. Overall, our findings depict that Italian LHAs have different approaches. This study highlights that, despite best practices, several areas require monitoring and intervention. Moreover, some barriers characterize Italian health communication strategies, notably the variability of information across and within regions and on average low website readability.

▶ Machine learning-based models for prediction of innovative medicine reimbursement decisions in Scotland

WANG, Y., TOLLEY, K., FRANCOIS, C., *et al.*

2025

Journal of Epidemiology and Population Health 73(1): 202802.

https://doi.org/10.1016/j.jeph.2024.202802

Objective This study aimed to investigate the critical factors for reimbursement decisions of innovative medicines in Scotland and to explore the feasibility of machine learning models for predicting decisions. Method All appraisals for innovative medicines issued by the Scottish Medicines Consortium (SMC) from 2016 to 2020 were screened to extract decision outcomes and 24 explanatory factors. SelectKBest with chi-square test was used for factor selection. The factors with P-value <0.05 were considered to have statistically significant associations with decision outcomes and were selected. Six machine learning models including decision tree, random forest, support-vector machine, Xgboost and K-nearest neighbours and logistic regression were used to build models with selected factors. Indicators comprising accuracy, precision, recall, F1-score were used to evaluate the performance of models. Result A total of 111 appraisals were identified, among which, 47 medicines were recommended, 48 recommended with restricted use and 16 not recommended. Seven were identified to be significant and selected for the prediction models. The factors of request for restriction on indication by manufacture, uncertainty of economic evidence, validation of primary outcomes and acceptance of comparator were identified as the most important predictors for SMC decisions. Four models had good prediction performance with both accuracy and F1-score over 0.9 in the internal validation, and random forest had the best prediction performance. Conclusion Low uncertainty of economic evidence, validated primary outcomes and accepted comparators were significantly associated with positive SMC decisions. Machine learning models may be feasible for predicting reimbursement decisions in the future.

Economie de la santé

Health Economics

▶ For Better or Worse? Subjective Expectations and Cost-Benefit Trade-Offs in Health Behavior: An Application to Lockdown Compliance in the United Kingdom

CONTI, G. ET GIUSTINELLI, P.

2025

Health Economics 34(5): 912-1012.

https://doi.org/10.1002/hec.4942

ABSTRACT We study the determinants of voluntary compliance in the early phase of the COVID-19 pandemic. Using rich data on subjective expectations we collected during the spring 2020 lockdown in the UK, we estimate a simple model of compliance choice with uncertain costs and benefits whose estimates quantify the utility trade-offs underlying compliance. Using these estimates, we decompose group differences in compliance into components due to preferences vis-à-vis expectations and compute the monetary compensation required for different groups to comply. We find citizens face intuitive trade-offs between costs and benefits of noncompliance, with the largest costs being the disutility of passing away from COVID-19 and the psychological cost of being caught transgressing, and the largest benefit being preserving own mental health. Significant heterogeneity exists across groups, with women's higher compliance being explained by gender differences in both preferences and expectations, while vulnerables' higher compliance being mainly driven by differences in preferences. The response of individual behavior to others' behavior, too, varies across personal characteristics and circumstances. Our findings underscore the importance for public health policies to take into account behavior-relevant heterogeneity in citizens' preferences, expectations, and responses to others.

Price transparency in health care: Bargaining incentives and patient responses

FENG, Y.

2025

Journal of Health Economics 102: 102998.

https://doi.org/10.1016/j.jhealeco.2025.102998

This paper studies the impact of price transparency on healthcare prices, using a natural experiment involving the gradual disclosure of medical procedure prices on a state-run website. The study finds that negotiated allowed amounts decreased by 5.1% for surgical procedures and 9.1% for radiology procedures, which have higher average allowed amounts and attracted more price requests on the website. In contrast, for lab procedures, the evidence is mixed and does not point to a clear effect. The observed reductions are primarily driven by provider-insurer negotiations rather than patient price shopping. Price reductions were consistent across all providers and insurers, regardless of whether their prices were listed on the transparency website, and extended to providers in neighboring states.

Transporting difference-in-differences estimates to assess health equity impacts of payment and delivery models

IANNI, K., CHEN, A., RODRIGUES, D., *et al.*

2025

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Abstract Objective To demonstrate the use of transportability methods to extend findings from payment model evaluations to groups of historically underserved beneficiaries. Study Setting and Design We used a simulation study to transport the effects of the Comprehensive Primary Care Plus (CPC+) model to a target population of Black fee-for-service (FFS) Medicare beneficiaries living outside the original 18 CPC+ regions. Our main outcome variable was total Medicare spending per beneficiary per year (pbpy). Data Sources and Analytic Sample We simulated practice-level spending in 18 CPC+ regions and 32 non-CPC+ regions (1200 practices per region). We calibrated the simulation parameters to values from the literature and then varied four key parameters to create 16 realistic simulation scenarios. These scenarios varied the representativeness of practices in CPC+ regions that joined CPC+ (i.e., the sample) relative to the target population by changing the distribution of Black beneficiaries across practices and the distribution of practices across regions. Practices were characterized by their experience with the Medicare Shared Savings Program (SSP) and system/hospital ownership because these are known to modify the effect of CPC+ on spending. Principal Findings Across the 16 simulation scenarios, transporting the treatment effect of CPC+ to Black FFS beneficiaries in non-CPC+ regions yielded median treatment effects that ranged from $15.5 pbpy smaller to $10 pbpy larger than in the sample. These differences are roughly the same magnitude as the estimated overall effect of $13 pbpy. Conclusions The Center for Medicare and Medicaid Innovation has pledged to put equity at the center of its demonstration models. However, offering models in limited geographic areas with voluntary provider participation may result in unrepresentative samples. Naively generalizing CPC+ effects from geographically limited, voluntary samples to all Black FFS beneficiaries could be misleading. Under some circumstances, transportability methods can be used to estimate effects in this target population.

Can financial incentives improve access to care? Evidence from a French experiment on specialist physicians

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2024

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In France, addressing balance billing is essential for equitable healthcare access and reducing physician income disparities. The National Health Insurance (NHI) introduced financial incentive programs, namely the "Contract for Access to Care" (CAS) in 2014 and the "Option for Controlled Pricing" (OPTAM) in 2017, to encourage physicians to reduce extra fees and adhere to regulated prices. This study analyzed the impact of these programs on self-employed physicians using a comprehensive administrative dataset covering specialist physicians from 2005 to 2017. The dataset comprised 9891 surgical specialists (30,972 observations) and 6926 medical specialists (21,650 observations) between 2005 and 2017. Applying a difference-in-differences design with a two-way fixed effect model and matching through the «Coarsened Exact Matching» method, the study examined CAS and/or OPTAM membership effects on physicians' activity and fees. The results indicate that both the CAS and OPTAM successfully enhance access to care. Physicians treat more patients, particularly those with lower incomes who might have previously avoided care because of the extra fees. However, an increased patient load translates to a higher workload for physicians. Despite a fee increase, it was observed to be smaller than the surge in activity. Furthermore, if all physicians are appropriately rewarded for their efforts, this improvement in access comes at a cost to NHI. This study's findings provide crucial insights into the nuanced effects of these financial incentive programs on physicians' behavior, highlighting the tradeoff between improved access and increased NHI costs. Ultimately, these findings underscore the complexity of balancing financial incentives, physician workload, and healthcare accessibility in pursuit of a more equitable healthcare system.

▶ Instrumental variables in the cost of illness featuring type 2 diabetes

KOLE, K., ZICK, C. D., BROWN, B. B., *et al.*

2025

Health Services Research 60(3): e14412.

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Abstract Objective To ascertain how an instrumental variables (IV) model can improve upon the estimates obtained from traditional cost-of-illness (COI) models that treat health conditions as predetermined. Study Setting and Design A simulation study based on observational data compares the coefficients and average marginal effects from an IV model to a traditional COI model when an unobservable confounder is introduced. The two approaches are then applied to real data, using a kinship-weighted family history as an instrument, and differences are interpreted within the context of the findings from the simulation study. Data Sources and Analytic Sample The case study utilizes secondary data on type 2 diabetes mellitus (T2DM) status to examine healthcare costs attributable to the disease. The data come from Utah residents born between 1950 and 1970 with medical insurance coverage whose demographic information is contained in the Utah Population Database. Those data are linked to insurance claims from Utah's All-Payer Claims Database for the analyses. Principal Findings The simulation confirms that estimated T2DM healthcare cost coefficients are biased when traditional COI models do not account for unobserved characteristics that influence both the risk of illness and healthcare costs. This bias can be corrected to a certain extent with instrumental variables. An IV model with a validated instrument estimates that 2014 costs for an individual age 45?64 with T2DM are 27% (95% CI: 2.9% to 51.9%) higher than those for an otherwise comparable individual who does not have T2DM. Conclusions Researchers studying the COI for chronic diseases should assess the possibility that traditional estimates may be subject to bias because of unobserved characteristics. Doing so may be especially important for prevention and intervention studies that turn to COI studies to assess the cost savings associated with such initiatives.

▶ Excess healthcare utilization and costs linked to chronic conditions: a comparative study of nine European countries

POLANCO, B., ONA, A., GEMPERLI, A., *et al.*

2025

European Journal of Public Health 35(2): 216-227.

https://doi.org/10.1093/eurpub/ckaf012

The increasing prevalence of chronic conditions is a significant challenge for healthcare systems worldwide, not only from a public health perspective but also for the aggregate cost that these represent. This paper estimates the additional use of healthcare services due to chronic health conditions and their associated costs in nine European countries. We analyzed inpatient and outpatient healthcare utilization using longitudinal data (Survey of Health, Ageing and Retirement in Europe [SHARE]). We implemented a difference-in-differences approach across multiple time periods. Monetary estimates were derived using WHO-CHOICE healthcare service costs. To compare countries, we calculated the healthcare cost burden of chronic conditions as a percentage of total health expenditure. People with chronic conditions require significantly more healthcare services than those without such conditions, averaging three additional outpatient visits and one extra overnight inpatient stay annually. These patterns vary across countries. In Germany, outpatient care usage is particularly high, with an average of four additional visits, while Switzerland leads in inpatient care with two extra overnight stays. The associated costs also differ widely, influenced by variations in healthcare demand, service pricing, and the prevalence of chronic conditions in each country. Chronic conditions significantly increase healthcare utilization, and demographic trends suggest this demand will continue to grow steadily. This rising pressure poses serious challenges for healthcare systems, necessitating a shift toward more efficient service delivery models.

▶ Private Equity-Owned Physician Practices Decreased Access To Retinal Detachment Surgery, 2014-22

SINGH, Y., CARDENAS, G. B., TORABZADEH, H., *et al.*

2025

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Private equity (PE) firms have increased their ownership stake across health care sectors in the US. PE's focus on short-term profitability may decrease the provision of unprofitable services, reducing access for patients in vulnerable populations. This is a particular concern for certain eye conditions such as retinal detachment, for which access to timely surgery is necessary to prevent irreversible vision loss and for which reimbursement is below cost for the fee-for-service Medicare population. Using a difference-in-differences approach, we examined changes in the provision of retinal detachment repair by 535 physicians in PE-acquired practices and 1,070 matched controls during the period 2014-22. Relative to matched controls, physicians in PE-acquired practices decreased the number of retinal detachment repairs by 19.6 percent after acquisition. These findings shed light on how PE acquisitions can affect the provision of services that do not present financial opportunities for investors. As nearly 30 percent of retina specialists are affiliated with PE firms nationally, further investigation into PE's impact on access for patients is warranted to determine whether PE acquisitions require patients to travel longer distances or have longer wait times, which could have serious effects on patient outcomes.

▶ What are the policy options for regulating private equity involvement in health care? A review of policies implemented or considered in seven high-income countries

TRACEY, M., SCHULMANN, K., TILLE, F., *et al.*

2025

Health Policy 156: 105312.

https://doi.org/10.1016/j.healthpol.2025.105312

Over the past two decades, private equity investment in health care has increased substantially. Proponents argue that private equity can optimize and improve health services, while critics warn that the business model of these firms is not aligned with the social values of care delivery and has harmful consequences for health systems and patients. It remains unclear to what extent — and how — subnational, national and supranational governments have attempted to regulate this activity. The purpose of this study therefore was to identify examples of implemented and proposed policy options for regulating private equity activity within health care, with the goal of elucidating the policy options available to regulators. We conducted a narrative review to identify proposed or implemented policy instruments in selected high-income countries, grouping them by type using a conceptual framework based on the works of Milton Friedman and Avedis Donabedian. Our search identified several examples of proposed or implemented policy options for addressing private equity activity in the countries under review. Most of these intervention examples fall into the category of disclosure, while only one focused on regulation of outcomes. Our study suggests that while some countries have started to develop policy interventions to directly address the role of private equity in health care, other countries do not specifically regulate private equity activity.

▶ Private equity expansion and impacts in united states healthcare

UNRUH, L. ET RICE, T.

2025

Health Policy 155: 105266.

https://doi.org/10.1016/j.healthpol.2025.105266

Over the past two decades, private equity (PE) firms–private investors that use large pools of money to buy into and restructure companies–have become increasingly involved in U.S. healthcare ownership and management. PE's goal of acquiring quick financial gains is typically accomplished by assigning debt to the facilities and practices it buys, cutting labor costs, changing services to the most lucrative, upcoding diagnostic codes to raise prices, and merging, shutting down, or selling practices. This study shows that private equity has expanded into nearly every corner of U.S. healthcare, and in some sectors, such as hospitals, nursing homes and physician specialties, quite significantly. The PE business model is theorized to be incompatible with high quality, efficient, accessible healthcare. Empirical research supports this framework to some extent. Few studies find evidence for better healthcare quality/patient outcomes or lower expenditures. A few studies find better access in profitable areas for PE, and three find lower operating costs and/or higher operating margins, which may have negative impacts in other healthcare system outcomes. A few studies show no difference in various healthcare system outcomes. Otherwise, the preponderance of studies indicates worse or mixed (mostly worse) outcomes with PE ownership. PE involvement in healthcare is greater in the U.S. than Europe, but there is potential for it to reach similar levels in Europe. Federal and state policy initiatives to regulate PE in U.S. healthcare are in the incipient stage and would benefit greatly by more research on PE's impacts.

▶ Predicting healthcare costs with diagnoses recorded in primary and secondary care: an analysis of linked records

WANG, S., ANSELMI, L., LAU, Y. S., *et al.*

2025

Social Science & Medicine 378: 118157.

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Most risk-adjustment models rely on diagnoses recorded during previous contacts in the same care setting to predict service use and cost. When diagnostic information from multiple settings has been used, studies have not examined how diagnoses recorded in different care settings influence model performance. Using a single set of diagnostic indicators recorded in primary or secondary care can incentivise case-finding and treatment outside hospital, but may reduce model fit if secondary care diagnosis indicates higher levels of severity. Using linked primary and secondary care records for 12.8 million patients in England, we used 205 chronic conditions recorded in primary care to complement those recorded during recent hospital admissions. We examined predictions of hospital use and cost for different population groups and considered the related incentives and implications for efficiency and fairness. Most patients (56%) had at least one condition ever recorded in primary care, while only 15% had at least one recorded in secondary care in the previous two years. Adding diagnoses recorded only in primary care as a separate additional set of predictors improved the model fit for total costs, planned and unplanned costs, elective and emergency admissions, outpatient visits, and emergency department attendances. Using a single set of diagnoses recorded in either setting did not improve model fit, except for outpatient visits. Including primary care diagnoses reduced under and over- compensation and increased the predicted service needs of younger patients in less deprived areas and older patients in more deprived areas.

▶ A Review of Heterogeneity in Comparative Economic Analysis, with Specific Considerations for the Decentralized US Setting and Patient-Centered Care

WILLIS, M. S., NILSSON, A. ET NESLUSAN, C. A.

2025

PharmacoEconomics 43(6): 601-616.

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Patient-centered care emphasizes individual preferences, but insurer coverage decisions—based on population-level evidence—may restrict treatment options for patients who differ from the average. This highlights the importance of considering heterogeneity, which refers to differences in health and cost outcomes that are systematically linked to variations in factors like patient characteristics, insurer policies, and provider practices. Failing to account for heterogeneity in economic evaluations can lead to suboptimal decisions, inferior outcomes, and inefficiency. This study aimed to assess the tools and methods for addressing heterogeneity in economic evaluations, examine the extent to which, and how, heterogeneity has been addressed in US cost-utility studies, and provide insights and recommendations to promote more fuller consideration of heterogeneity in US economic evaluations. We reviewed and adapted a seminal taxonomy of heterogeneity to the US setting, highlighting key drivers like patient preferences and insurance design. Methods for addressing heterogeneity in economic evaluations were also reviewed and summarized. We used data from the Tufts Medical Center Cost-Effectiveness Analysis Registry to assess empirical practices in US cost-utility applications, specifically the frequency, types, and impact of a subgroup analysis, and whether rationales for including or excluding subgroups were provided. The revised taxonomy highlights key drivers of heterogeneity in the diverse and decentralized US healthcare ecosystem, such as the diversity of patient preferences and in non-patient factors like access to healthcare providers and insurance coverage. Methods to explore, confirm, and incorporate heterogeneity into a comparative economic analysis exist, but are often challenged by data availability. In addition to the trade-off between potential efficiency gains and increasing uncertainty in comparative value estimates, ethical implications of stratified decisions were highlighted in the literature. We found that a subgroup analysis was rare, and primarily performed for clinical factors like age and disease severity. Only 2 of the 85 studies published between 2015 and 2022 with subgroup-level results were found to consider non-patient factors, and none considered preferences. One-third of studies reported incremental cost-effectiveness ratios differing by more than 50% from the unstratified estimate. No studies provided a rationale for omitting a subgroup analysis, and only two motivated inclusion of a subgroup analysis, limiting our ability to assess the appropriateness of these decisions. Despite well-documented methods to address heterogeneity, its application is limited in US cost-utility studies, especially regarding patient preferences and non-patient factors. As these factors often drive real-world health outcomes and costs in the USA, proper consideration of, and reporting on, heterogeneity is essential to avoid erroneous market access decisions, suboptimal patient outcomes, and economic inefficiency. Future efforts, including work by an upcoming Professional Society of Pharmacoeconomics and Outcomes Research Task Force, should continue to refine taxonomies and emphasize the importance of addressing heterogeneity.

Environnement et santé

Environmental Health

What are the Revealed and Stated Population Preferences for Environmental Sustainability in Healthcare? A Scoping Review

DESTERBECQ, C., HARRISON, M. ET TUBEUF, S.

2025

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Collective changes in healthcare practices are required to ensure real environmental gains. As patient-centred care is increasingly considered to enhance the ability of health systems to meet the expectations of the population, it is crucial for policymakers and health professionals to account for the preferences of the wider public regarding environmentally friendly healthcare. This article synthesises and appraises evidence from empirical studies to understand how people value environmental concerns when making decisions within medical-related or pharmaceutical sectors.

Correction: What are the Revealed and Stated Population Preferences for Environmental Sustainability in Healthcare? A Scoping Review

DESTERBECQ, C., HARRISON, M. ET TUBEUF, S.

2025

PharmacoEconomics 43(6): 629-629.

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Les implications pour la santé publique des politiques de neutralité carbone: différents impacts pour différents leviers

JEAN, K., MOUTET, L., MASUREL, I., *et al.*

2025

Environnement, Risques & Santé 24(3): 160-168.

En impliquant des modifications dans les déterminants environnementaux et comportementaux de la santé, les politiques de neutralité carbone peuvent avoir des co-bénéfices conséquents en termes de santé publique. L'utilisation de méthodes d'évaluation quantitative d'impact sanitaire sur la base des données détaillées fournies par les scénarios de neutralité carbone permet d'obtenir des estimations de ces co-bénéfices. C'est ce que nous illustrons ici, sur le périmètre de la France métropolitaine, sur la base des scénarios de l'Agence de la transition écologique (ADEME) Transition(s) 2050, en considérant trois déterminants de la santé : l'activité physique liée à la mobilité active, la qualité de l'air et l'alimentation. La démarche consiste tout d'abord à modéliser, sous les différents scénarios de neutralité carbone, l'évolution des facteurs environnementaux ou comportementaux affectant la santé ; ensuite, à sélectionner des relations dose-réponse reliant ces expositions au risque de mortalité ; et enfin, à évaluer quantitativement les implications sanitaires de ces scénarios en utilisant différentes métriques : décès évités, années de vie ou espérance de vie gagnées, coûts intangibles de santé évités. Les résultats provisoires permettent d'estimer que, sous les scénarios les plus favorables, ces co-bénéfices de politiques de neutralité carbone pourraient être de l'ordre de 100 000 décès évités par an au sein de la population adulte par rapport aux pratiques et tendances actuelles, du fait des bénéfices liés à l'activité physique, à la qualité de l'air et à l'alimentation. Les résultats suggèrent également que des visions différentes dans les choix de société en vue de l'atteinte de la neutralité carbone peuvent se traduire par des impacts sur la santé potentiellement très différents.

▶ Twenty years evaluating the health impact of urban policies in the city of Barcelona

LOPEZ, M. J., PEREZ, K., CONTINENTE, X., *et al.*

2025

Health Policy 155: 105306.

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The objective of this study is to describe the evaluation of the impact of non-health policies in health in the city of Barcelona, describing the main methodologies used and the main outcomes measured, as well as sharing some of the lessons learned during these years. We reviewed the health evaluation of urban policies carried out by the Public Health Agency of Barcelona during the last 20 years, excluding those promoted by the health sector. For each evaluation we have described the evaluative design, the methodology used to collect data and the main outcomes measured. More than 20 non-health policies have been evaluated in terms of health in the city of Barcelona. In most cases a quasi-experimental design has been used, having measured outcomes related to health and health-determinants, using quantitative methodology in all cases, combined with qualitative methodology in some evaluations.

▶ Rapid review on healthy ageing interventions that incorporate action on climate change and sustainability in cities and communities

PATRICK, R., NOY, S., MCKEW, M., *et al.*

2025

Health & Place 93: 103435.

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Objectives Intersecting global trends of population ageing and climate change have far-reaching implications for health and sustainability in cities and community contexts. Older adults are highly impacted by climate change, and yet reports of the implementation of the World Health Organizations' Age-Friendly Cities and Communities (AFCC) approach rarely examine the impacts of climate change on older adults. There is limited research on climate change interventions that target older populations. This rapid scoping review characterizes existing evidence in this area, including climate and health-related interventions involving older populations around the world. Methods The PCC framework (Population, Context, Concept) guided the implementation of this rapid scoping review. Peer reviewed articles were sourced from Scopus (Elsevier), Greenfile, Academic Search Complete (EBSCO), Global Health (OVID) and Google Scholar. Grey literature was sourced from Google Scholar, Google and relevant international websites. Inclusion criteria were grey and academic publications in English, after the year 2000 and described an intervention. Screening was undertaken on Covidence software and critically appraised using MMAT and AACODS tools. The AFCC framework was used to guide analysis and interpretation. Results Twenty-five articles were included. The review found a paucity of literature describing age-friendly cities and community interventions that considered health-related impacts of climate change on older adults, issues for rural communities and those in developing nations. Climate change was rarely mentioned other than for context in the peer-reviewed literature, and the grey literature was similarly sparse. Peer-reviewed literature was top-down, focusing on disasters and older adults' vulnerability, whilst the grey literature privileged older adult agency and potential contribution to addressing climate change. Successful interventions were programs that positioned older adults as active, empowered participants. Conclusions Climate change justice and resilience should be incorporated explicitly into the AFCC framework. Greater information exchange between Global North and Global South and inclusion of diverse perspectives (i.e., Indigenous knowledge, people with disabilities and/or experiencing homelessness) will enhance policy efforts. Similarly, recognition of the broader impacts of climate change on the fundamental pre-requisites for health across the lifespan such as food, water and energy security are required. Older adults should be seen as a valuable resource integral to the design and implementation of innovative interventions with climate resilience, healthy ageing focus.

Réduire l'empreinte carbone dans les soins : le cas des dispositifs inhalateurs dans l'asthme et la BPCO

REVUE PRESCRIRE

2025

Prescrire : la revue 2025(498): 299-306.

Diverses mesures visent à réduire l'impact environnemental des dispositifs d'inhalateurs : pour les firmes, fabrication d'aérosols-doseurs avec des gaz à moindre effet de serre ; pour les prescripteurs, intégration d'un critère de choix environnemental pour remplacer les aérosols-doseurs par des inhalateurs de poudre ou de brumisat quand ils sont adaptés à la situation du patient; pour les pharmaciens exerçant en établissement de santé, priorisation des présentations de spécialités à moindre impact écologique lors des commandes et de la dispensation; pour l'ensemble des soignants, sensibilisation des patients à leur rôle pour réduire l'impact environnemental des médicaments.

Can care ethics help healthcare systems address their environmental harms? Findings from focus groups with members of the UK public

SAMUEL, G., MACFARLANE, M. ET BRIGGS, S.

2025

Social Science & Medicine 376: 118113.

https://doi.org/10.1016/j.socscimed.2025.118113

Bioethics scholars have become increasingly interested in moral questions associated with healthcare's environmental harms. Much of this scholarship has remained in the theoretical space, where ethical reasoning is underpinned by certain obligations and the implementation of top-down principles. Drawing on twelve focus groups with members of the UK public, this paper aims to bring a sociological ethics of care approach to these discussions. In fulfilling this aim, we highlight how moral decision-making occurs in the context of interrelationships with others, and not simply according to top-down principles. We show how, in line with an ethics of care approach, participants prioritised caring needs based on those in close relational proximity, meaning that emphasis was placed primarily on themselves and their loved ones, followed by other humans and the NHS, and finally the environment. At the same time, we contribute to the ethics of care scholarship by showing how such relation-based hierarchical caring was affected by various socio-cultural and political factors–what we have called 'contextual caring'. We note four factors: access to healthcare, capability of care work, increasing understanding of the relationship between humans and the environment, and societal norms of environmental citizenship. We stress the importance of considering these socio-cultural and political factors in any examination of how relation-based hierarchical care occurs in practice. We reflect on the implications of our focus group findings for policy measures towards addressing the UK NHS's environmental harms.

État de santé

Health Status

Soigner les enfants dans les foyers de la protection de l'enfance

KHENNOUF, M., LEBOURDAIS, J., ROUSSELON-CHARLES, V., *et al.*

2025

Médecine Vol. 21(2): 79-84.

https://doi.org/10.1684/med.2025.1069

Cette enquête qualitative sur la santé de l'enfant protégé a été menée dans 5 foyers de l'enfance. Issu de milieux vulnérables et souvent défavorisés, l'enfant protégé présente une santé physique et psychique dégradée associée à un manque de suivi médical. Des inégalités d'accès aux soins ont été mises en lumière dans cette étude, avec un parcours médical révélant des situations de refus de soins discriminatoires. Du fait des traumatismes passés vécus, les problématiques en lien avec les troubles réactionnels de l'attachement sont privilégiées par certains soignants pour expliquer des atypies neurodéveloppementales au risque de retards diagnostiques.

Impact of a Cancer Diagnosis on Educational, Employment, Health-Related Quality of Life, and Social Outcomes among Young Adults: A Matched Cohort Study of 401 Cancer Survivors Aged 15-24 in England

MATTOCK, R., MARTIN, A., BECKETT, A. E., *et al.*

2025

Social Science & Medicine 376: 118078.

https://doi.org/10.1016/j.socscimed.2025.118078

Background Globally, cancer incidence is rising fastest among young people. Existing literature on acute health shocks, including cancer diagnoses, focuses on older working-aged adults. Methods Matched cohort study involving 401 young cancer survivors (aged 15-24) in the BRIGHTLIGHT study and 765 UK Household Longitudinal Study controls without cancer. Participants were matched on sex, age, ethnicity, index of multiple deprivation (IMD) quintile, non-cancer health conditions, and follow-up duration. Regression models assessed economic, educational, social, health-related quality of life (HRQoL), and mental health outcomes at 6(T1), 12-18(T2), and 24-36 months (T3) post-diagnosis. Results Compared to matched controls, those with cancer were: less likely to be in employment, education, or training at T1 (OR = 2.03, p<0.001) but not at T3 (OR = 0.96, p = 0.18), because transitioning from unemployment or economic inactivity into education was more common (24% vs 3% between T1 and T3); less likely to live in parental households at T1 (OR = 0.54, p<0.001) and T3 (OR = 0.59, p<0.001); and more likely to experience relationship breakdown (23% vs 12% between T1 and T3). Differences in mental health and HRQoL declined over time (mean difference compared to matched controls: T1: -0.07, p < 0.001; T2 and T3: -0.01 p>=0.55). Economic outcomes, mental health and HRQoL utility scores were persistently worse among more severe cancer cases. Conclusions Despite having initially poorer health and economic outcomes, cancer survivors in this cohort caught up with their peers within 3 years. Linked clinical data showed those with more severe diagnoses were affected most, indicating scope for improved psychosocial and economic support.

Health benefits of leisure-time physical activity by socioeconomic status, lifestyle risk, and mental health: a multicohort study

NYBERG, S. T., FRANK, P., PENTTI, J., *et al.*

2025

Lancet Public Health 10(2): e124-e135.

https://doi.org/10.1016/s2468-2667(24)00300-1

BACKGROUND: Regular physical activity is recommended for all aged 5 years and older, but the health benefits gained might differ across population subgroups. The aim of this study was to examine these benefits in terms of years lived free from major non-communicable diseases in subgroups with varying levels of risk factors. METHODS: Our analysis was based on a multicohort study of initially healthy European adults from the IPD-Work Consortium and initially healthy participants from the UK Biobank study. Self-reported leisure-time physical activity levels at baseline (1986-2010) were categorised as low (no or very little), intermediate (between low and recommended levels), and WHO-recommended (≥2·5 h of moderate or ≥1·25 h of vigorous physical activity per week). We divided the study population into 36 overlapping subgroups based on socioeconomic factors, lifestyle, and mental health at baseline, and assessed disease-free years between ages 40 years and 75 years for both the overall population and subgroups, accounting for coronary heart disease, stroke, type 2 diabetes, cancer, asthma, and chronic obstructive pulmonary disease. FINDINGS: 14 IPD-Work studies were assessed and six studies were excluded due to missing outcome data and unavailable data for pooling, resulting in the inclusion of eight studies with 124 909 participants. After the exclusion of 7685 participants due to prevalent diseases and 9265 due to missing data, the sample consisted of 107 959 initially healthy European adults (63 567 [58·9%] females and 44 392 [41·1%] males) from the IPD-Work consortium. For the UK Biobank sample, 9 238 453 million individuals were invited, 8 736 094 (94·6%) were non-respondents, and 502 359 participated in the baseline examination. After the exclusion of 73 460 participants, 428 899 participants had data on at least one measure of physical activity. 236 258 (55·1%) were female and 192 641 (44·9%) were male. During 1·6 million person-years at risk, 21 231 IPD-Work participants developed a non-communicable disease, while 101 319 UK Biobank participants developed a non-communicable disease over 4·8 million person-years at risk. Compared with individuals with low physical activity, those meeting the recommended physical activity levels during leisure-time gained an additional 1·1 (95% CI 1·0-1·2) to 2·0 (1·7-2·3) disease-free years, depending on sex and study. In males from the IPD-Work and UK Biobank cohorts, greater gains in disease-free years were observed in current smokers (2·4 [95% CI 2·1-2·8]) versus never smokers (0·7 [0·5-0·9]); those with low education (1·4 [1·1-1·7]) versus high education (0·8 [0·7-1·0]); low socioeconomic status (1·7 [1·5-2·0]) versus high socioeconomic status (0·9 [0·7-1·1]); and those with (1·6 [1·3-1·9]) versus without depressive symptoms (1·0 [0·9-1·1]; p value range <0·0001-0·0008). Similar differences were seen in women for smoking (2·3 [95% CI 1·9-2·7] vs 0·9 [0·7-1·1]), socioeconomic status (1·7 [1·4-2·0] vs 0·8 [0·5-1·0]), depressive symptoms (1·4 [1·1-1·7] vs 1·0 [0·9-1·1]), and for heavy drinkers compared with moderate drinkers (1·4 [1·1-1·6] vs 0·9 [0·7-1·1]; p value range <0·0001-0·010). No differences in physical activity-related health gains were observed between risk groups and non-risk groups by BMI, history of depression, and, in men, alcohol use (p value range 0·11-0·86). INTERPRETATION: In addition to confirming the association between leisure-time physical activity and increased disease-free years across population subgroups, our findings show that these health benefits are often more pronounced among individuals with pre-existing health risks or disadvantaged backgrounds than in those with more favourable risk factor profiles. This suggests that enhancing population-wide physical activity initiatives could help reduce health disparities, while incorporating physical activity into targeted strategies addressing social disadvantage, unhealthy lifestyles, and depression might enhance their effectiveness. FUNDING: Wellcome Trust, UK Medical Research Council, US National Institute on Aging, and Research Council of Finland.

Géographie de la santé

Géographie of Health

Effects of urban greenspace on time to major adverse cardiovascular events among women with breast cancer in the US: Insights from the Greater Milwaukee, WI Area

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2025

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Background Cardiovascular (CV) disease (CVD) remains a significant concern among breast cancer (BC) survivors, particularly following potentially cardiotoxic treatments, such as anthracyclines and anti-HER2 drugs, which increase the risk of major adverse CV events (MACE). Social determinants of health (SDOH) and environmental factors influence health outcomes, including those related to CVD. Urban greenspace has been associated with CV and cancer-related health benefits, yet its specific impact on MACE among BC survivors remains unknown. Objective This study aims to investigate the association between urban greenspace and time to first MACE incidence among individuals with BC after being treated with cardiotoxic therapies in the greater Milwaukee, WI area. Methods A retrospective cohort study was conducted using electronic medical records from the Froedtert Health System, linked to the National Death Index. Cox proportional hazards regression models were used to assess the association between percent tree canopy cover and MACE-specific hazards, adjusting for sociodemographic, clinical, and neighborhood-level factors. Results Among the 849 women included, 44.6 % experienced a MACE. Adjusted models indicated an 18 % reduction in MACE-specific hazard (HR: 0.82, 95 % CI: 0.70, 0.96) and a 20 % reduction in MACE-specific hazard (HR: 0.80, 95 % CI: 0.67, 0.97) for women in the second and third quartiles of percent tree canopy cover, respectively, compared to the women in the first (lowest) quartile. However, we did not observe a risk difference for women living in the fourth quartile of tree canopy. Racial/ethnic disparities in greenspace exposure and MACE incidence were evident, with Non-Hispanic Black (NHB) women having a lower proportion living in areas with the highest tree canopy cover and a higher MACE incidence (61.9 %) compared to Non-Hispanic White (NHW) women (41.6 %), who had the highest proportion residing in areas within the 4th quartile of tree canopy cover. Discussion Our findings suggest that urban tree canopy is associated with time to incident MACE among BC survivors receiving cardiotoxic treatments. These results underscore the importance of considering socioenvironmental factors in CardioOncology care and highlight the benefits of greenspace in mitigating CV complications among individuals with BC. Future research should delve into individual lifestyle and behavioral factors, environmental factors, and biological mechanisms that may underlie these associations. Additionally, longitudinal studies should be conducted to evaluate greenspace-based interventions for BC survivors, aiming to advance precision CardioOncology interventions. Observed racial/ethnic disparities in MACE incidence underscore the urgent need for equity-focused interventions addressing greenspace access and MACE-related disparities.

▶ Excess mortality, COVID deaths, and spatial accessibility to health care services in the conterminous United States

CHEN, X.

2025

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Since the onset of COVID 19, the pandemic has put extra burden on mortality in the United States. This study aims to investigate the regional variations of death rates and the associations between excess deaths and the underlying population characteristic and spatial access to medical services during the pandemic. To this end, this study estimated the excess deaths in 2020 and the travel times to the nearest healthcare facilities, PCP ratios, and medical facility to population ratios at the county level in the conterminous United States. Coupling the death data with population characteristics, socio-economic factors, health factors and access to healthcare facilities, this study employed spatial statistical methods, including global and local spatial autocorrelation analyses, bivariate spatial analysis and geographically weighted generalized linear regression to investigate their relationships. The results revealed that the impact of COVID varied across the country. The South, particularly the Deep South, was hit the hardest. Compared to the spatially varying relationship between COVID deaths, unemployment, minority, smoking rates and excess deaths, poverty was the primary factor linked to excess deaths nationally. While the access to healthcare services was not associated with excess deaths in general, it did vary significantly between counties with high/low death rates.

▶ Systemic planning vs. individual choice: The optimal matching for urban healthcare facilities and patient population

HUANG, L. P., ZHANG, K. X., ZHENG, Q. Y., *et al.*

2025

Applied Geography 179: 103641.

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Urban healthcare facilities planning faces a challenge that patient population tend to bypass lower-level for higher-level healthcare facilities despite increased distance and cost along with overcrowding at high-level facilities and underutilization at low-level ones. This phenomenon and its challenges are presumably influenced by individual behaviors of patients and urban healthcare facilities planning by local governments. This paper examines this phenomenon through optimal matching of patient population to healthcare facilities in two approaches representing top-down planning and bottom-up individual choice. More specifically, planning matching spatially assigns the patients to the closest facilities and choice matching, including multinomial logit matching or game theoretic matching, optimally selects facilities based on patient choices. Using Hangzhou, China as a test bed with 194 healthcare facilities and 588 residential communities, this research has found that: (1) the inconsistency between planning and individual choice leads to population bypassing certain facilities; (2) the trade-offs between healthcare service level and community-facility distance are consistent across matchings; (3) systemic planning outperforms individual choice concerning distance and actual utility while the reverse holds true for service level and indirect utility; (4) certain thresholds exist beyond which neither approach excels, suggesting a mix of the two approaches.

Neighborhood matters: An exploration of neighborhood-level disadvantage and cancer preventive behaviors in Hispanic youth with unhealthy weight

LOVAN, P., GRAEFE, B., PORTER, A., *et al.*

2025

Health & Place 93: 103474.

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Objectives The present study aimed to assess the associations between the youth's cancer preventive behaviors (CPB) (i.e., healthy dietary intake and physical activity), parent stress, parent socio-demographic characteristics (i.e., education, household income, and marital status), and neighborhood influences measured by the Area Deprivation Index (ADI) in a sample of Hispanic families who have youth with unhealthy weight. Additionally, we examined whether parent stress mediated the relationship between ADI and youth CPB. Methods Baseline data from 280 Hispanic youth (Mage = 13.01 ± 0.83; 52.1 % females; MBody Mass Index (BMI) Percentile = 94.55 ± 4.15) and their parents (Mage = 41.87 ± 6.49; 88.2 % females) who enrolled in an RCT were used. Self-reported data on youth dietary intake and physical activity, parent stress, and parent socio-demographic characteristics were collected. Neighborhood impact was examined using ADI, a validated measure to classify neighborhood disadvantage (e.g., housing quality and neighborhood income) using data from the US Census Bureau. Structural Equation Modeling was used (CPB as a latent variable) to evaluate the study model. Results Our findings indicated significant associations between ADI and youth CPB ($b = -0.17$, $p = .019$), and parent stress ($b = 0.23$, $p = .001$). However, parent stress did not mediate the relationship between youth ADI and CPB. Conclusion Youth living in disadvantaged neighborhoods report less engagement in cancer preventive behaviors including poorer food intake quality and less physical activity, which may increase their risk of cancer. Future research should evaluate neighborhood resources to encourage physical activity and healthy eating.

The challenge of access to healthcare services as a condition for territorial equity. A methodological approach for sparsely populated rural areas

SANCHEZ-MATEOS, H. M. ET RUIZ PULPON, A. R.

2025

Health Policy 156: 105310.

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Access to basic healthcare services poses a significant challenge for sparsely populated rural areas within the European Union, impacting fundamental principles such as territorial equity. This challenge is intensified by current demographic trends, including depopulation and ageing, which affect both the availability of healthcare professionals and the increased demand for efficient healthcare services for the older population. To address this issue, the present study adopts a methodological approach that uses distance and transport time to measure the accessibility of different rural municipalities to healthcare facilities. This study focuses on the Autonomous Region of Castilla-La Mancha (Spain) as a representative territory for the abovementioned demographic dynamics. The main results indicate a clear relationship between negative demographic indicators and poorer healthcare access, especially in rural areas with limited transportation infrastructure. Access to primary healthcare is generally well distributed, with more than 90% of rural population living within 15 minutes of a basic healthcare facility, while hospitals are less accessible for the rural population, with more than 40% of the sample needing 30 minutes to reach one. The sample is also highly sensitive to the population density and ageing rates. As a significant contribution, a universal methodology is presented that can be applied to other rural territories with a significant ageing population, enabling territorial planning policies to optimize quality healthcare in line with the active ageing policies promoted by the United Nations.

On the Modifiable Areal Unit Problem (MAUP) in healthcare accessibility measurement via the two-step floating catchment area (2SFCA) method

TAO, Z., ZHANG, R., LIU, C., *et al.*

2025

Health & Place 93: 103468.

https://doi.org/10.1016/j.healthplace.2025.103468

The widely used two-step floating catchment area (2SFCA) method for healthcare accessibility measurement might be biased due to the Modifiable Areal Unit Problem (MAUP), which remains unknown. This study calculates and compares healthcare accessibility via the Gaussian-based 2SFCA method at various spatial scales to identify the scale effects. We also compare various spatial aggregation approaches at the township scale to examine the zoning effects, including geometric centroids, population centroids, government residences and a hybrid population-weighted average travel time approach. Taking Lhasa city as the study area, the grid-based travel time estimation method is adopted to reflect the influence of the physical environment. The results reveal significant scale effects in the application of the 2SFCA method. Using population centroids to represent the spatial distribution of population within townships can yield more accurate accessibility results, while the accessibility measured based on geometric centroids might be considerably biased. The population-weighted average travel time approach, which aggregates grid-scale travel times to the township scale, also ensures high accuracy of accessibility measurement. The population-weighted average travel time approach and the population centroid approach are more effective in mitigating potential scale effects on accessibility results with limited population data. These findings are valuable for researchers to apply accessibility methods properly and support reliable policy implications based on accessibility results.

Handicap

Disability

Psychosocial Adversities in Adulthood Among Individuals Raised with Family Members with Disabilities

AMILON, A., OSTERGAARD, S. V. ET OLSEN, R. F.

2025

Social Science & Medicine 372: 118016.

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Despite millions of individuals worldwide growing up with family members who have disabilities, little is known about how this experience is associated with long-term outcomes. We address this gap by examining how growing up with a parent and/or sibling with a disability is associated with individuals' psychosocial situation in adulthood. Using retrospective information from the 2020 wave of the Survey of Health, Impairment and Living Conditions in Denmark (SHILD, N = 15,699), we explore how growing up in a family with disability is associated with loneliness, social support, general self-efficacy, subjective well-being, and feelings of resentment in adulthood. Our results from linear probability models suggest that growing up with a parent and/or sibling with a disability increases the likelihood of experiencing loneliness, low subjective well-being, and reduced self-efficacy. Additionally, we find that individuals who grow up in a family with disability are more likely to report a lack of social support and heightened feelings of resentment. We conclude that growing up with a parent and/or sibling with a disability is associated with a wide range of psychosocial adversities in adulthood. However, having a disability oneself is even more detrimental for psychosocial outcomes. These findings highlight the need for strengthened support for families with disabilities to improve psychosocial outcomes and break cycles of intergenerational disadvantage.

Ressenti des patients en situation de handicap moteur sur leur prise en charge en cabinet de médecine générale : une étude qualitative

JAMME, L., BLANGEZ, A., VINCENT, Y. M., *et al.*

2025

Médecine Vol. 21(2): 85-90.

https://doi.org/10.1684/med.2025.1070

Contexte. Les personnes en situation de handicap (PSH) atteintes d'un handicap moteur représentent 8 % des PSH des Français. Leur parcours de soins est jonché d'obstacles physiques, financiers, organisationnels et parfois humains. Le médecin généraliste (MG), comme interlocuteur de premier recours, a un rôle fondamental dans leur adhésion au soin. Évaluer le ressenti des PSH concernant leur prise en charge par les MG paraissait donc essentiel afin d'identifier ces obstacles et d'en déduire de potentiels axes d'amélioration. Objectifs. L'objectif principal de cette étude était d'évaluer le ressenti des PSH moteur concernant leur prise en charge en médecine générale. L'objectif secondaire était d'identifier des axes d'améliorations rapportés par les patients. Méthode. Des entretiens semi-dirigés ont été effectués auprès de PSH moteur et ont fait l'objet d'une analyse qualitative s'inspirant de la méthode de théorisation ancrée. Résultats. Dix entretiens individuels ont été réalisés. Les résultats montraient que le ressenti des PSH s'organisait sous trois composantes : des besoins particuliers inhérents à leur handicap et à leur dépendance (médicale, humaine et matérielle), une exigence et des revendications particulières envers le corps médical, mais aussi une indulgence envers les MG. Les axes d'améliorations identifiés s'articulaient autour d'une meilleure transparence, de davantage de temps médical consacré, d'une augmentation de l'empathie, de l'éducation et de l'adaptation des MG. Conclusion. Les conclusions de cette étude originale pourront servir de support pour de futures améliorations de la formation et des pratiques des MG afin de faciliter le parcours des PSH moteur en soins primaires.

Factors influencing the experience of empowerment in Flemish (proxy) budget holders: A regression analysis

PATTYN, E., GEMMEL, P., WILLEMS, R., *et al.*

2025

Health Policy 155: 105295.

https://doi.org/10.1016/j.healthpol.2025.105295

The Flemish government implemented a cash-for-care scheme in 2017, allocating a personal budget (PB) as a voucher or cash budget to persons with physical and intellectual disabilities to increase budget holders' empowerment. However, the literature shows that personal (inherent to budget holders) and contextual factors (inherent to cash-for-care schemes) potentially have an impact. This study, therefore, reports on Flemish budget holders' empowerment and its associated factors. A survey was developed, examining personal and contextual factors related to empowerment. A convenience sample with multiple recruitment sources (via policy, user-, and care organization support) was used to recruit participants. Data collection took place from April 4, 2022, to October 31, 2022, and data were analyzed using bivariate and linear regression analyses. The survey was completed by 224 budget holders. The complexity of administrative procedures, educational level, private financial resources, and presence of an (in)formal care network were not associated with Flemish budget holders' empowerment. However, the regression analyses showed that knowledge of the care and well-being sector, PB allocation type (cash and combination versus vouchers), and respondent type (proxies representing the budget holder versus people with disabilities as respondents) predicted empowerment. Knowledge and flexibility in PB use are significantly associated with higher empowerment scores. Enhancing knowledge about the (disability) care sector is thus a key objective when implementing a cash-for-care scheme.

Hôpital

Hospital

Hospital Capital Expenditures Associated With Prices And Hospital Expansion Or Withering, 2010–19

BEAULIEU, N. D., HICKS, A. L. ET CHERNEW, M. E.

2025

Health Affairs 44(5): 546-553.

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Prices charged by hospitals in commercial markets are, on average, high and growing rapidly, and they vary within markets. The narrative around these facts has focused on hospitals gaining market power through mergers and acquisitions. Hospitals may also increase their market power by investing in capacity, services, or amenities that, although potentially desirable, increase demand and differentiate them from competitors. Independent of market-power changes, average prices may increase if volume shifts toward high-price hospitals. This study investigated the market dynamics linking hospital capital expenditures during the period 2010–19 to changes in volume, market share, and prices. We found that hospitals investing more in capital gained market share and raised prices, whereas hospitals investing relatively less in capital lost market share and increased prices less. Taken together, these forces perpetuate a cycle of expanding and withering hospitals. Study findings suggest important limits to antitrust as a mechanism to address high and rising prices, and the findings could inform policies to forestall or eliminate the financial decline of withering hospitals, thereby preserving access and promoting competition.

Association of a State-Wide Alternative Payment Model for Rural Hospitals With Bypass for Elective Surgeries

BOURNE, D. S., SUN, Z., JACOBS, B. L., *et al.*

2025

Health Services Research 60(3): e14442.

https://doi.org/10.1111/1475-6773.14442

ABSTRACT Objective This study aimed to measure the changes in rural hospital bypass for 11 common elective surgeries following the implementation of the Pennsylvania Rural Health Model (PARHM), a global budget payment model. Study Setting and Design We leveraged a natural experiment arising from the phase-in of PHARM in Pennsylvania. We conducted a comparative interrupted time series analysis to assess changes in rural hospital bypass, comparing trends in rural hospital bypass among patients in hospital service areas (HSAs) with PARHM-participating hospitals to patients in control HSAs with hospitals eligible for but not participating in PARHM. Analyses accounted for staggered entry into PARHM and examined outcomes up to 4 years post-entry. Data Sources and Analytic Sample We used Pennsylvania all-payer visit-level inpatient discharge data (2016–2022) to measure rural hospital bypass, encompassing 175,138 surgeries. Principal Findings The average bypass rate for elective surgeries was 59.9%, with an increasing trend observed during the study period. Overall, differential changes in bypass rates between PARHM-participating and control HSAs were not statistically significant, from a low of 0.53 percentage points (−8.17–9.22) among Cohort 2 HSAs and a high of 5.96 percentage points (−4.63–16.55) among Cohort 1 HSAs. However, among critical access hospitals, PARHM participation was associated with a significant relative increase in levels and trends in bypass rates compared to controls, from a low of 9.12 percentage points (2.45–15.79) among Cohort 1 HSAs and a high of 29.70 percentage points (12.54–46.86) among Cohort 2 HSAs. These relative increases were largely due to a stable rate in PARHM-participating HSAs and a marked decrease in control HSAs. Conclusions This study fills a gap in the relationship between global budgets and hospital bypass. Although PARHM did not broadly alter rural bypass rates overall, the differential increase in bypass among HSAs with CAHs participating in PARHM suggests meaningful effect heterogeneity, warranting further research and analysis of impacts on patient outcomes.

Rural Hospital Closures Led To Increased Prices At Nearby 'Surviving' Hospitals, 2012–22

CARROLL, C. ET CHANG, J. Y.

2025

Health Affairs 44(5): 563-571.

https://doi.org/10.1377/hlthaff.2024.00700

Rural hospitals in the US have closed at a rapid pace in recent years, raising concerns about decreased access to care and declining competition in rural markets. Because prices paid by commercial health insurance plans are negotiated between hospitals and insurers, hospital closure may give "surviving" hospitals increased leverage to negotiate higher prices. Using commercial claims data, we studied the effect of hospital closure on the prices charged by nearby surviving hospitals. We found that hospital closures during the period 2014–18 led to a 3.6 percent increase in prices at surviving hospitals, driven by larger price increases in the three to four years after closure. Price effects were concentrated among surviving hospitals with market power—hospitals with system affiliations and hospitals operating in less competitive markets. We also found that closed hospitals charged lower prices than nearby hospitals in the preclosure period. Thus, closure eliminated low-price hospital options from rural markets. Overall, our findings suggest that hospital closure can have a meaningful impact on commercial prices. Policies targeting rural hospitals should consider the anticompetitive effects of closure, in addition to devoting continued attention to access to and quality of care.

▶ Does Physician-Hospital Vertical Integration Signal Care-Coordination? Evidence from Mover-Stayer Analysis of Commercially Insured Enrollees

ENCINOSA, W. ET DOR, A.

2025

Journal of Health Economics 101: 102997.

https://doi.org/10.1016/j.jhealeco.2025.102997

The sharp growth in physician groups being purchased by hospitals has sparked extensive policy debate, with little evidence on the merits of such integration. We fill the gap by examining care-coordination under integration. We exploit the fact that integration varies across MSAs and focus on PPO patients with employment-based moves between MSAs. We develop a mover-stayer model with heterogenous effects to examine whether vertically integrated practices treat patients differently, or whether they just treat different patients. Moving to a more integrated market causes an increase in care coordination indices. Specifically, moving to an area with more specialty care integration causes an increase in team referrals between primary and specialty care, less lab and imaging use, less out-of-network care, and reductions in spending. That is, systems are able to narrow the scope of specialty services overall, hence creating greater social efficiencies. Moving to a market with more integrated primary care causes an increase in preventive care, decreased inpatient use by women, but an increase in spending. JEL I11, L14, C22

▶ The impact of budget cuts on individual patient health: Causal evidence from hospital closures

GHISLANDI, S., RENNER, A. T. ET VARGHESE, N. E.

2025

Journal of Health Economics 101: 102975.

https://doi.org/10.1016/j.jhealeco.2025.102975

Public finance constraints following the 2008 financial crisis in Europe often affected the hospital sector. This paper investigates i) the causal health impacts of reduced hospital supply, and ii) possible mechanisms to explain these. Using a staggered difference-in-differences framework, we study the effects of hospital closures on outcomes of all heart attack patients admitted to an Italian hospital between 2008 and 2015. Results show that closures increased in-hospital mortality by 10 % and length-of-stay by 0.3 days, but had no impact on readmissions. We explore potential mechanisms using different estimation approaches, and show that increased travel time following closures explains most of the mortality effect.

▶ Is frequent emergency department use a complement or substitute for other healthcare services? Evidence from South Carolina Medicaid enrollees

GIANNOUCHOS, T. V., PIRRALLO, R. G. ET WRIGHT, B.

2025

Health Services Research 60(3): e14430.

https://doi.org/10.1111/1475-6773.14430

Abstract Objective To compare healthcare services utilization across the healthcare system between frequent and non-frequent emergency department (ED) users among Medicaid enrollees in South Carolina. Study Setting and Design We conducted a retrospective, longitudinal study of individuals with at least one ED visit in 2017 in South Carolina and identified their healthcare services visits over 730 days (2 years) after their first ED visit. We classified individuals based on intensity of ED use: superfrequent (≥9 ED visits/year), frequent (4–8 ED visits/year), and non-frequent ED users (≤3 visits/year). We estimated differences between the three groups of ED users and non-ED hospital and office-based visits using multivariable two-part regression models. Data Sources and Analytic Sample We used statewide Medicaid claims from January 2017 to December 2019 for ED users aged 18–64 years with continuous Medicaid enrollment. We analyzed data on all frequent and superfrequent users and selected a 4:1 random sample among all non-frequent users (~half of all non-frequent users). Principal Findings The study included 52,845 ED users, of whom 42,764 were non-frequent, 7677 frequent, and 2404 superfrequent users. Within 2 years from the date of their first ED visit, superfrequent ED users averaged 38.3 ED visits, frequent ED users 10.9 ED visits, and non-frequent ED users 2.6 ED visits ($p < 0.001$). Compared with non-frequent users, frequent and superfrequent ED users had more comorbidities and chronic conditions on average (1.6 vs. 3.5 vs. 6.4, $p < 0.001$). Both frequent and superfrequent users had more hospital visits beyond the ED overall (marginal effects: 0.23, 95% CI 0.18–0.27; 0.40, 95% CI 0.29–0.50), and more outpatient office visits overall (marginal effects: 4.39, 95% CI 2.52–6.27; 9.23, 95% CI 5.66–12.81), including primary care and most specialists' visits, compared with non-frequent users. Conclusions Frequent ED users utilized non-ED hospital and outpatient office-based healthcare services significantly more than non-frequent ED users. These findings can guide tailored interventions using data across the healthcare system to efficiently coordinate care, contain costs, and improve health outcomes for these individuals.

The Voice of Sacrifice: The Silence of Healthcare Professionals in the Service of Productivity. The Case of a French Hospital

GLAUZY, A. ET MONTLAHUC-VANNOD, A.

2025

Social Science & Medicine 377: 118110.

https://doi.org/10.1016/j.socscimed.2025.118110

For more than half a century, French hospitals have been subjected to the logics of New Public Management (NPM), which compel healthcare professionals to navigate increasing demands for economic efficiency. Rooted in a managerial ideology, these logics generate significant distress among healthcare professionals, who struggle to reconcile the socio-relational aspects of care with new standards of standardization dictated by performance tools and indicators. While this distress remains a taboo in hospital settings, this study examines how the silence surrounding professional suffering becomes a lever for productivity within these managerial frameworks. Drawing on ethnographic research conducted through observations and interviews in a French hospital specializing in severe liver and pancreatic diseases, our findings reveal that silence, initially imposed by a managerial culture that denies vulnerability, evolves into a resource for healthcare professionals. It allows them to transcend their subjectivity to meet productivity demands. Grounded in the theory of the psychodynamics of work, we argue that healthcare professionals use silence as a means of self-sacrifice, aiming to fulfill productivity expectations and conform to identity norms shaped by the organizational culture.

Foreign doctors and hospital quality: Evidence from the English NHS

LALIOTIS, I.

2025

Labour Economics 94: 102707.

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This paper examines the relationship between hospital quality and the share of foreign doctors in the English NHS. Baseline findings suggest that heart attack mortality is higher in hospitals with greater shares of foreign doctors practising relevant specialties. Robustness tests and heterogeneity analyses indicate that this association is specific to Acute Myocardial Infraction (AMI) treatment and is driven by hospitals that are smaller, of lower-quality, and ill-equipped to provide optimal care. When explicitly considering for treatment type, AMI mortality does not vary with the share of foreign AMI specialists in hospitals capable to access certain treatment technologies within 150 min. Overall, the results suggest that higher AMI mortality is not caused by foreign-trained AMI doctors but instead reflects structural challenges and resource-driven hiring patterns in constrained hospitals, which tend to rely more heavily on foreign doctors to mitigate worse outcomes. Further research is needed to better understand the allocation of foreign doctors to underperforming hospitals and its implications for healthcare delivery.

Hospital resilience in the Face of Covid-19 in France: A multilevel analysis of the impact of past practice quality on cancer surgery resumption

MALLEJAC, N. ET OR, Z.

2025

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The COVID-19 pandemic disrupted routine hospital services, causing a substantial backlog of surgeries in 2020. This study investigates hospital resilience in resuming activities during the pandemic, focusing on the impact of pre-pandemic adoption of enhanced recovery after surgery protocols (ERAS) in digestive cancer surgery. ERAS involves patient-centered care protocols proven to improve care process and outcomes but are not systematically implemented in hospitals. We define hospital resilience as the ability to maintain and resume surgery levels in the second half of 2020 during the pandemic. Using French national hospital data for digestive cancer surgeries, we categorized hospitals by the intensity of their ERAS volume before the pandemic and estimated a multilevel model allowing to control for hospital characteristics and pandemic conditions in the area they are situated. Results show that, all else being equal, hospitals that implemented ERAS before the pandemic absorbed the surgical backlog and recovered their pre-pandemic activity level more quickly. High-volume hospitals and specialized cancer centers were also quicker than other hospitals in resuming surgical operations. The findings highlight the differences in care practices across hospitals and the importance of quality protocols in bolstering hospital resilience during health crises. Beyond improving patient outcomes, widespread adoption of such protocols could enhance healthcare resource utilization and help to mitigate broader economic and environmental pressures.

▶ Ratios soignants à l'hôpital : bonne ou fausse bonne idée ?

MASINI, K. ET DE LARD-HUCHET, B.
2025
Gestions Hospitalières 2025(644): 195-198.

La loi n° 2025-74 du 29 janvier 2025 relative à l'instauration d'un nombre minimum de soignants par patient hospitalisé a finalement vu le jour, et dans quel contexte ! Adoptée alors même que nous ne disposions pas à ce moment de loi de financement de la sécurité sociale (LFSS) pour 2025 ! C'est dire si le serpent de mer a la peau dure. De nombreuses questions parlementaires y ont fait référence ces dernières années, en lien avec les problématiques de conditions de travail, d'attractivité et de pénurie des ressources paramédicales à l'hôpital. Pour autant, le débat perdure. Alors que contient vraiment ce texte, et qu'en penser ? (R.A.)

▶ The supply of nursing labor in French hospitals: Outflows, part-time work and motherhood

PORA, P.
2025
Labour Economics 94: 102716.
https://doi.org/10.1016/j.labeco.2025.102716

This paper quantifies the supply of nursing labor in French hospitals over the course of hospital nurses' careers, using detailed longitudinal payroll tax data matched with birth certificates and census data. Over the first ten years of their careers, the nursing hours supplied to hospitals decrease by more than a third on average. This decline is primarily driven by hospital nurses leaving these positions, and to a lesser extent by transitions to part-time schedules within hospital nursing jobs. Nurses who leave hospital positions predominantly transition to other jobs, usually within the healthcare sector, rather than to non-employment. These job transitions are mostly unrelated to motherhood, whereas having children frequently leads mothers to switch to part-time schedules within hospital nursing jobs. In fact, without the effect of motherhood, the prevalence of part-time work among hospital nurses would be significantly lower. Finally, while hospitals offset the loss of nursing hours due to unanticipated staff departures by hiring new nurses, they struggle to compensate for nursing hours lost to part-time transitions.

▶ Hospital Involvement in Screening for and Addressing Patients' Health-Related Social Needs.

SINGH, S. R. ET HOGG-GRAHAM, R.
2025
Medical Care Research and Review 82(3): 269-275.
https://doi.org/10.1177/10775587241310922

The number of hospitals screening patients for health-related social needs (HRSNs) has increased substantially in recent years, yet little is known about the extent to which hospitals invest in programs or strategies aimed at addressing identified needs. Using data from the 2022 American Hospital Association (AHA) Annual Survey for 2,468 non-federal general medical and surgical hospitals, this study explored screening rates and related interventions for eight HRSNs: housing, food insecurity, utilities, interpersonal violence, transportation, employment or income, education, and social isolation. Sample hospitals screened for an average of 6.1 HRSNs and had programs or strategies for an average of 5.4 HRSNs. Hospitals that screened their patients for HRSNs were significantly more likely to invest in interventions aimed at addressing these needs. Serving patients more holistically by addressing both medical and social needs has the potential to improve health outcomes and ultimately reduce health disparities.

Physicians' responses to time pressure: Experimental evidence on treatment quality and documentation behaviour

SOUCEK, C., REGGIANI, T. ET KAIRIES-SCHWARZ, N.

2025

Health Policy 155: 105302.

https://doi.org/10.1016/j.healthpol.2025.105302

Background In hospitals, decisions are often made under time pressure. There is, however, little evidence on how time pressure affects the quality of treatment and the documentation behaviour of physicians. Setting We implemented a controlled laboratory experiment with a healthcare framing in which international medical students in the Czech Republic treated patients in the role of hospital physicians. We varied the presence of time pressure and a documentation task. Results We observed worse treatment quality when individuals were faced with a combination of a documentation task and time pressure. In line with the concept of the speed-accuracy trade-off, we showed that quality changes are likely driven by less accuracy. Finally, we showed that while documentation quality was relatively high overall, time pressure significantly lowered the latter leading to a higher hypothetical profit loss for the hospital. Conclusions Our results suggest that policy reforms aimed at increasing staffing and promoting novel technologies that facilitate physicians' treatment decisions and support their documentation work in the hospital sector might be promising means of improving the treatment quality and reducing inefficiencies potentially caused by documentation errors.

The impact of C-level positions on hospital performance: A scoping review of top management team outcomes

ZUCHOWSKI, M. L., HENZLER, D., ALSCHER, M. D., *et al.*

2025

Health Policy 157: 105346.

https://doi.org/10.1016/j.healthpol.2025.105346

Background As hospitals expand their roles within transforming health systems, their governance structures must adapt to changing demands, with novel leadership structures evolving to meet new challenges. Objective This review aims to provide a comprehensive overview on the evidence of the influence of hospital C-level positions on key organisational performance parameters. It maps key concepts from the existing literature relating to hospital performance and leadership and identifies mediators and moderators of top management team impacts based on the Upper-Echelons-Theory. Methods The scoping review was conducted according to the Joanna Briggs Institute methodology and Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews, covering studies from 1990 to the present. Eligible studies addressed at least one identifiable hospital C-Suite role and one hospital-wide leadership effect. Results Out of 5430 articles identified, 60 were included. The analysis covers seven distinct C-Suite roles and their effects on six performance dimensions: quality of care, structural quality, patient satisfaction, work satisfaction, financial performance, and process efficiency. Conclusions The findings suggest that the influence of C-Suite positions on hospital performance is multifaceted, with the Chief Executive Officer's influence extending beyond financial performance to shaping the quality of care. Additionally, the impact of newer roles such as the Chief Quality Officer, as well as leadership roles like the Chief Medical Officer and Chief Nursing Officer, appear to depend on a collaborative approach and alignment with the Chief Executive Officer. From a policy perspective, the findings emphasise that hospital governance, shaped by regulations, determines key performance indicators and strategic priorities.

Inégalités de santé

Health Inequalities

Health inequality attributions and support for healthcare policy

BAUTE, S.

2025

Social Science & Medicine 374: 117946.

https://doi.org/10.1016/j.socscimed.2025.117946

This article examines popular explanations of health inequality and introduces a typology distinguishing between behavioural, biological, environmental, and healthcare attributions. Using data from an original survey among 6,000 individuals in Germany, the findings reveal that explanations for the social gradient in health vary by income and political ideology. Lower-income groups primarily attribute health inequality to the healthcare system, whereas higher-income groups attribute them to behavioural factors. Similarly, right-wing individuals tend to view income-related health disparities as a consequence of individual behaviour, while left-wing individuals primarily attribute them to environmental health risks. Furthermore, the study shows that such health inequality attributions are associated with citizens' support for government responsibility for healthcare provision and willingness to pay higher taxes to improve healthcare. These findings suggest that health inequality attributions play an important role in the democratic legitimacy of healthcare policies. Divergent views on the causes of health disparities may undermine solidarity within healthcare systems.

Socioeconomic area deprivation and its relationship with dementia, Parkinson's Disease and all-cause mortality among UK older adults: a multistate modeling approach

BEYDOUN, M. A., GEORGESCU, M. F., WEISS, J., *et al.*

2025

Social Science & Medicine 379: 118137.

https://doi.org/10.1016/j.socscimed.2025.118137

The study analyzed the association of area-level socioeconomic status (SES) with the risk of all-cause dementia, Parkinson's Disease (PD), and all-cause mortality using a multistate approach. Data from the UK Biobank were used (N = 363,663 50+y individuals, ≤15y follow-up), and Cox proportional hazards and multistate parametric models including Weibull regression were conducted, while cardiovascular health was tested as a potential mediator. In multistate models, socioeconomic area-level deprivation, measured by the Townsend Deprivation Index (TDI) z-score, was positively associated with the hazard of going from healthy into the 3 states of PD, dementia, and all-cause mortality (i.e. transitions 1: HR = 1.06, 95 % CI:1.02–1.10, P = 0.005, 2: HR = 1.19, 95 % CI: 1.16–1.22, P < 0.001 and 3: HR = 1.19, 95 % CI: 1.18–1.21, P < 0.001), with no association detected for transitions 4 (PD→Dementia), 5 (PD→Death), or 6 (Dementia→Death). Cardiovascular health did not mediate these associations. Socioeconomic area-level deprivation was directly associated with reduced survival rates from Healthy into Dementia, PD and Death.

Monitoring privilege for health equity: building consensus on indicators to monitor socioeconomic advantage through a modified Delphi survey

CARRAD, A., SCHRAM, A., TOWNSEND, B., *et al.*

2025

Social Science & Medicine 379: 118193.

https://doi.org/10.1016/j.socscimed.2025.118193

The World Health Organization's Commission on Social Determinants of Health highlighted the need to measure and monitor the inequitable distribution of power, money, and resources across society. Efforts to monitor health inequity focus on disadvantage rather than advantage or privilege, and on proximal health outcomes rather than distal social and structural determinants of health. This study aimed to identify a comprehensive set of key indicators to measure and monitor socioeconomic advantage. Following a literature review to establish an initial set of indicators (n = 79), we used a three-round, online Delphi survey to build consensus among a panel of participants with diverse disciplinary backgrounds and with expertise related to socioeconomic inequity. Participants rated indicators for relevance to the concept of socioeconomic advantage using a seven-point Likert scale and ranked priority indicators among selected indicator categories. Thirty-one, 21 and 15 experts—predominantly from Australia— participated in the first, second and third round, respectively. Sixty-four of 76 indicators reached consensus, including all indicators within the 'Wealth' and 'Income/wealth inequality' categories. Priority rankings of economic indicators were clear: gross income and disposable income were the highest ranked income indicators; net wealth was the highest ranked wealth indicator. Ranking of 'Connections and signalling indicators' was less distinct; however, elite secondary schooling, and attendance at exclusive events received the highest mean ranks. Monitoring of these socioeconomic advantage indicators is crucial for identifying whether policy and governance is ultimately shifting the dial on equitably distributing resources for improving health equity outcomes.

Socioeconomic inequalities in mental health difficulties over childhood: a longitudinal sex-stratified analysis using the UK Millennium Cohort Study

CHUA, Y. W., SCHLUTER, D., PEARCE, A., *et al.*

2025

Social Science & Medicine 378: 118159.
https://doi.org/10.1016/j.socscimed.2025.118159

Stark socioeconomic inequalities in childhood mental health have been widely reported. Understanding whether they vary with age, by type of difficulty or sex can inform public health policies to tackle socioeconomic inequalities. We investigated the effects of early life childhood socioeconomic circumstances (SECs) (maternal education and household income) on developmental trajectories of externalising and internalising difficulties in childhood and adolescence, in males and females from the UK-representative Millennium Cohort Study (N=15383). We estimated the Slope Index of Inequality (SII) (absolute difference between the most versus least advantaged) using linear mixed-effects regression models, on parent-reported Strengths and Difficulties Questionnaire externalising and internalising difficulties score, at 5, 7, 11, 14, and 17 years(y). The mean externalising score was high at 5y (4.8 [95%CI: 4.7, 4.9]) and decreased slightly, while mean internalising score increased over childhood, reaching 3.9 [3.8, 4.1] by 17y, with a steeper trend for females in adolescence. Lower maternal education was associated with greater externalising scores at 5y (SII, Male: 3.0 [2.7 to 3.3]; Female: 2.7 [2.4, 3.0]) with inequalities decreasing slightly up to 17y (SII Male: 2.4 [2.0 to 2.7], Female: 2.5 [2.1, 2.8]). Inequalities in internalising scores increased slightly over childhood (SII Female 5y: 1.3 [1.1, 1.6]; 17y: 1.9 [1.5, 2.3]; SII Male 5y=1.6 [1.3, 1.8], 17y=1.8 [1.5, 2.2]). Patterns were similar using household income. Disadvantaged SECs are associated with persistently higher levels of parent-reported mental health difficulties up to 17y, with larger effects on externalising than internalising difficulties, but little differences by sex or socioeconomic measure.

Educational disparities in dementia incidence and healthcare utilization: evidence from a cohort study in Italy

CRISTOFALO, A., CASCINI, S., CESARONI, G., *et al.*

2025

Social Science & Medicine 380: 118233.
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While educational disparities in dementia incidence are well-known, whether and to what extent they persist beyond dementia onset is less explored. In this study, we investigated educational disparities in the risk of dementia diagnosis in administrative health records (dementia incidence) and subsequent healthcare utilization among dementia patients. We analysed the Lazio Region Longitudinal Study (Italy) from 2012 to 2022. We applied Cox regression to investigate disparities in dementia incidence and three subsequent healthcare utilization outcomes (all-cause hospitalizations, potentially preventable hospitalizations, and emergency visits). In a cohort of dementia-free 50–90-year-olds (907 453 men and 1 083 538 women), we found strong and age-patterned disparities in dementia incidence. Compared to highly-educated, the incidence in low-educated men and women was higher, especially at ages 50-64 (HR= 2.09, 95% CI: 1.69–2.58 and HR= 2.17; 95% CI: 1.71–2.74). In the follow-up of 27 158 men and 40 797 women incident dementia cases, low-educated had higher risk of all-cause hospitalizations (HR= 1.24; 95% CI: 1.16–1.32 and HR= 1.18; 95% CI: 1.09–1.27), potentially-preventable hospitalizations (HR= 1.27; 95% CI: 1.17–1.37 and HR= 1.19; 95% CI: 1.08–1.31) and emergency visits (HR= 1.33; 95% CI: 1.26–1.41 and HR= 1.27; 95% CI: 1.18–1.35). Disparities in hospitalization reduced after adjusting for health conditions pre-existing dementia identification, less so those in emergency visits. Overall, disparities in dementia incidence persisted to a lesser extent in subsequent healthcare utilization and were mostly accounted by pre-existing health conditions.

Equity in Health Care and Health: Contributions from Health Economics

CULLINAN, J. ET LORGELLY, P.

2025

Social Science & Medicine 372: 117997.

https://doi.org/10.1016/j.socscimed.2025.117997

A new era of inequality: profound changes to mortality in England, Scotland, and 10 major British cities

DE HARO MORO, M. T., SCHOFIELD, L., MUNOZ-ARROYO, R., *et al.*

2025

European Journal of Public Health 35(2): 235-241.

https://doi.org/10.1093/eurpub/ckaf008

Deeply concerning changes to UK health trends have been noted since the early 2010s, including a widening of mortality inequalities. Given the importance of urban areas to national health outcomes, we sought to address gaps in the evidence by examining trends in intra-city mortality inequalities across Britain, including assessing the impact of the peak COVID-19 pandemic period. Age-standardized mortality rates were calculated (for England, Scotland, and 10 major UK cities) by age (all ages, 0–64 years), sex, year (1981–2020), and country-specific and city-specific area-based quintiles of socio-economic deprivation. Trends in absolute and relative inequalities in mortality by country and city were analysed by means of the Slope Index of Inequality (SII) and the Relative Index of Inequality (RII), respectively. Profound changes to mortality trends and inequalities were observed across both nations and all cities in the decade up to 2020, including increases in death rates among the 20% most deprived populations of almost every city. For deaths at all ages, this was particularly evident in Leeds, Liverpool, Edinburgh, Dundee, and Glasgow. For 0–64 years, Scottish cities stood out. With few exceptions, both absolute and relative inequalities increased in the same time period. COVID-19 further increased death rates and inequalities. The analyses provide a hugely concerning picture of worsening mortality and widening inequalities across England and Scotland. When viewed in the context of the evidence for the impact of UK government austerity policies on population health, they represent a wake-up call for both current and future UK governments.

Inequalities in health and resources between siblings of individuals with and without mental health disorder: an observational study using the French national health data system

HEYER, T. ET TUPPIN, P.

2025

European Journal of Public Health 35(2): 359-365.

https://doi.org/10.1093/eurpub/ckae223

The aim of the present study was to describe the effect of an individual's mental health disorder on the resources of his or her adult siblings. A subject rarely analyzed on a large scale. The French National Health Data System (SNDS) collects data on individuals, including their characteristics and the types of healthcare used. A national observational sectional case–control study included individuals covered as of 1 January 2019 and receiving yearly at least one healthcare reimbursement in 2019 including their SNDS data collected from 2013 to 2018. The main variables of interest were a Complementary Universal Health Coverage (CUHC) granted to people who had limited resources. There is also a long-term disease (LTD) status qualifying also for 100% for a specific disease and an ecological index of social deprivation of the place of residence. Conditions were also collected using a specific tool including LTD and hospital diagnosis. Analyzed siblings included 280 709 cases with at least one member suffering from a mental health disorder and 561 418 randomly selected control individuals were addressed using a multilevel model. Siblings of people with mental health problems were more likely to benefit from CUHC or to live in the most deprived area. In addition, the study also highlighted the importance of parental background, which appears to be poorer than in the control population. Social inequalities are particularly marked among the siblings of a person suffering from mental health disorder. Further studies are needed to better understand and enlarge these observational results.

Immigrant Inequities in Uninsurance and Postpartum Medicaid Extension: A Quasi-Experimental Study in New York City, 2016–2021

JANEVIC, T., BIRNIE, L., BELFON, K., *et al.*

2025

American Journal of Public Health 115(5): 732-735.

https://doi.org/10.2105/ajph.2024.307968

Objectives. To determine if de facto postpartum Medicaid extension during the Families First Coronavirus Response Act (FFCRA) reduced immigrant versus US-born inequities in uninsurance. Methods. We assessed self-reported uninsurance at 2 to 6 months postpartum among people with Medicaid-paid births using the New York City Pregnancy Risk Assessment Monitoring System (PRAMS), comparing immigrant and US-born people. We created a pre-FFCRA cohort of 2611 births from 2016 to 2019 and a post-FFCRA implementation cohort of 1197 births from 2020 to 2021. We calculated risk differences using log binomial regression. Results. Self-reported postpartum uninsurance among immigrants decreased from 13.6% to 9.3% after FFCRA (adjusted risk difference = –4.9%; 95% confidence interval = –7.8%, –2.0%). Immigrant versus US-born inequities in postpartum uninsurance decreased except among Hispanic birthing people, among whom 1 in 6 reported they were uninsured during FFCRA, despite continued eligibility. Conclusions. De facto postpartum Medicaid extension decreased immigrant inequities in insurance coverage, but Hispanic immigrants may have been unaware of continued coverage. Public Health Implications. Postpartum Medicaid extension policies that are inclusive of all immigrants may decrease inequities, but community-integrated implementation is needed to raise awareness of coverage and advance postpartum maternal health equity. (Am J Public Health.

Living arrangements and chronic disease accumulation among native-born and immigrant older adults in Europe

JANG, S. Y., OKSUZYAN, A., VAN LENTHE, F. J., *et al.*

2025

Social Science & Medicine 373: 117954.

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Background Who we live with in later life significantly influences the daily care support we receive, potentially moderating chronic disease trajectories. For immigrants, this relationship is further complicated by cultural preferences for certain living arrangements. This study examines the differential role of living arrangements in chronic disease accumulation among native-born and immigrant older adults in Europe. Methods Using data from the Survey of Health, Ageing and Retirement in Europe (2006-2022), we analyze how living arrangements moderate the relationship between age, migration background, and the number of chronic diseases. We also conduct stratified analyses based on immigrants' countries of origin. All models employ inverse probability weights for panel attrition and panel-robust standard errors for longitudinal data. Analyses are conducted separately for men and women. Results Immigrants generally have a higher chronic disease burden than native-born individuals, although the size of this disparity varies by living arrangements. Among native-born men and women, living with a partner/spouse or family is related to fewer chronic diseases than living alone. Conversely, among immigrants, these benefits of shared living arrangements are absent for men and weaker for women. We also find that the role of living arrangements in chronic disease accumulation among immigrants varies by their country of origin, as supported by, for instance, a considerable chronic disease burden among immigrant women from low HDI countries who live as a family. Conclusion Older immigrants, particularly men from highly developed countries and women from less developed countries, may experience fewer health benefits from living with a partner or with family. Our findings indicate that these immigrant households may have excessive caregiving burdens, which could contribute to unhealthy aging among immigrants in later life.

Impact des violences subies sur la santé de femmes migrantes consultant dans deux policliniques parisiennes

KAOUTAR, B., ROUMIEU, S., AUDIFFRED, L., *et al.*

2025

Santé Publique vol. 37(2): 73-88.

https://doi.org/10.3917/spub.252.0073

Introduction : Les migrants représentent une population qui s'installe dans un pays étranger. En 2020, ils étaient estimés à 281 millions. Parmi les patients vus par le Comité pour la santé des exilés, 62 % déclarent avoir subi des violences. Les femmes migrantes sont particulièrement exposées aux violences de genre. Parmi les femmes migrant de la République démocratique du Congo vers le Cameroun, 39 % déclarent avoir subi des violences sexuelles, nettement plus que la population hôte, qui en déclare 3,9 %. But de l'étude : Rechercher l'impact des violences sur la santé physique et mentale des femmes migrantes dans des centres de premier recours de soins parisiens. Méthodes : Il s'agit d'une étude analytique transversale réalisée dans deux policliniques d'hôpitaux parisiens. Les femmes migrantes ont été interrogées sur les violences subies avant leur arrivée en France. Leurs antécédents médicaux et leur état de santé actuel ont été analysés en fonction des violences vécues. Résultats : 131 patientes migrantes ont été incluses sur une période de trois semaines. Originaires principalement d'Afrique subsaharienne (75 %), leur moyenne d'âge était de 43 ans et 59 % d'entre elles ont subi des violences. Un état de stress post-traumatique (ESPT) a été retrouvé chez 66 % des patientes ayant subi des violences et la moitié présentait un syndrome dépressif ou anxieux, tandis que ces syndromes n'étaient présents que chez respectivement 22 % et 20 % des migrantes du groupe sans violences. De plus, toujours chez les patientes ayant subi des violences, 48 % présentaient des symptômes cardiaques versus 26 %, 53 % des symptômes respiratoires versus 20 % et 58 % des symptômes gastro-intestinaux contre 23 % (p).

Detection of potential causal pathways among social determinants of health: A data-informed framework

KORVINK, M., BIONDOLILLO, M., VAN DIJK, J. W., *et al.*

2025

Social Science & Medicine 373: 118025.

https://doi.org/10.1016/j.socscimed.2025.118025

Introduction Understanding social determinants of health (SDOH) as a complex system is necessary for designing effective public health interventions. Traditional expert-driven approaches to mapping SDOH relationships, when used in isolation, are susceptible to subjective biases, incomplete knowledge, and inconsistencies across different domains of expertise. Additionally, SDOH variables often contain overlapping information, making it difficult to isolate unique SDOH constructs. A data-driven approach integrating dimensionality reduction and causal discovery can provide a more objective framework for identifying and mapping SDOH factors within a causal system. The data-driven method may serve as a starting point to overcome potential research biases in the development of causal structures. Methods An observational study was conducted using census tract-level SDOH data from the 2020 Agency for Healthcare Research and Quality (AHRQ) database. Principal Component Analysis (PCA) was applied to derive latent constructs from 157 SDOH variables across 85,528 U.S. census tracts. The Greedy Equivalence Search (GES) algorithm was then used to identify dominant causal pathways between these constructs. Results PCA-derived components explained substantial variance within each domain, with food access (71.1 %) and income (50.0 %) explaining the most within-domain variance. The causal graph revealed economic stability as a central determinant influencing education, employment, housing, and healthcare access. Education, access to care, and access to technology mediated many pathways. Discussion Findings highlight the interconnected nature of SDOH, emphasizing financial stability as a foundational determinant. The role of digital equity in health outcomes is increasingly significant. The data-driven approach may serve as an important tool to support researchers in the mapping of SDOH causal structures. Public Health Implications This study demonstrates the utility of combining PCA and GES to uncover causal pathways among SDOH constructs. Developing causal systems using data-driven methods provides an enhanced method for conducting public health assessments, identify optimal intervention points, and informing policy development.

Gender Inequality in Immigrants' Mental Health: The Legal Status Gradient

KREISBERG, A. N.

2025

Social Science & Medicine 377: 118111.

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Depression is a leading cause of global disease burden, and women report higher rates of depression than men. Among immigrants, gender disparities are more pronounced. But despite variation among immigrants by their legal status—which shapes correlates of mental health disorders—little is known about how and why legal status relates to gender inequalities in immigrants' depression. Using longitudinal data from the New Immigrant Survey, I find evidence that female immigrants have persistently higher likelihoods of a common depressive symptom, dysphoric mood, than male immigrants. Legal status is related to this disparity: there is a legal status gradient in dysphoria for immigrant women, but not for immigrant men. Accounting for processes of selection, some of the relationship between legal status and dysphoria for women is explained by healthcare resources and expectations for security. The results are consistent when predicting major depressive disorder, and the findings have implications for gender and population health.

Area-level socioeconomic status is associated with colorectal cancer screening, incidence and mortality in the US: a systematic review and meta-analysis

LAWLER, T. P., GIURINI, L., CARROLL, C. B., *et al.*

2025

Social Science & Medicine: 118212.

https://doi.org/10.1016/j.socscimed.2025.118212

Background Geographic disparities exist for colorectal cancer (CRC) in the United States (US). Area-level socioeconomic status (SES) may influence CRC outcomes through multiple pathways, including by influencing screening adherence. We completed a systematic review and meta-analysis of area-level SES and CRC incidence, mortality, and screening among US individuals. Methods Original research articles were identified from biomedical databases. Eligible studies reported associations between area-level SES at the census block or tract level with CRC incidence, mortality, or screening in a US-based sample. A fixed-effects meta-analysis was performed to estimate summary hazard ratios (HRs) or odds ratios (ORs) with 95% confidence intervals (CIs) for the associations between area-level SES and CRC outcomes. Results Twenty-six studies were included in the systematic review. Living in an area in the lowest SES quantile was associated with higher CRC risk (HR 1.37 [CI: 1.34-1.41]). Associations were similar in race-stratified analyses for White (HR 1.43 [CI: 1.39-1.47]), Black (HR 1.18 [CI: 0.96-1.44]), and Asian/Pacific Island racial status (HR 1.18, [CI: 1.08-1.28]). For individuals with CRC, lower area-level SES was associated with risk for overall mortality (HR 1.26 [CI: 1.23-1.29]) and CRC-specific mortality (HR 1.24 [CI: 1.22-1.26]). Lower area-level SES was associated with lower completion of recommended screening for CRC (OR 0.76 [CI: 0.74-0.79]). Conclusions Individuals who reside in areas with less socioeconomic resources have elevated risk for CRC incidence and mortality. Healthcare policies and interventions focused on low resource settings may increase uptake of preventative screening leading to a reduction in geographic disparities for CRC.

Examining COVID-19 Mortality Inequalities Across 169 Countries: Insights from the COVID-19 Mortality Inequality Curve (CMIC) and Theil Index Analysis

LOPEZ BARRERA, E., MILJKOVIC, K., BARNOR, K., *et al.*

2025

Health Policy 157: 105345.

https://doi.org/10.1016/j.healthpol.2025.105345

Background The COVID-19 pandemic has highlighted global disparities in health outcomes, with mortality driven by pre-existing comorbidities, demographic vulnerabilities, and systemic socioeconomic inequalities. These factors underscore the need for evidence-based policies to address health inequities and strengthen system resilience. Objective This study quantifies COVID-19 mortality disparities across 169 countries, focusing on obesity, age, and income dimensions, to inform equitable and effective policy interventions. Methods Using publicly available datasets, the COVID-19 Mortality Inequality Curve (CMIC) and Index (CMII) were applied to measure disparities, while the Theil Index decomposed them into within- and between-group components. Mortality data were analyzed at three time points—December 2020, August 2021, and February 2022—to capture the effects of vaccination campaigns. Results The Theil Index revealed significant reductions in mortality inequality among countries with lower obesity rates (from 1.43 to 0.80) and older populations (from 0.95 to 0.54), reflecting the impact of targeted vaccination efforts. However, income-based disparities showed limited improvement (Theil Index: 0.61 to 0.54), emphasizing persistent inequities in healthcare access. High-income countries achieved the most significant reductions in inequality due to early and widespread vaccination. Conclusions Tailored health policies prioritizing equitable vaccine distribution, data harmonization, and targeted interventions for obesity and age-related vulnerabilities are critical for reducing disparities and strengthening health system resilience during global crises.

Socioeconomic inequalities and ambient air pollution exposure in school-aged children living in an affluent society: an analysis on individual and aggregated data in Belgium

MUSTANSAR, T., TIMMERMANS, E. J., SILVA, A. I., *et al.*

2025

Health & Place 93: 103473.

https://doi.org/10.1016/j.healthplace.2025.103473

Background Individuals with lower socioeconomic status (SES) are at a higher risk of being exposed to adverse environmental factors. Children are more vulnerable to the harmful effects of air pollutants. Therefore, this study examined socioeconomic inequalities in air pollution exposure among children in Flanders, Belgium. Methods Data were used from 298 children (age range: 9–12 years), and from their parents who participated in the COGNition and Air pollution in Children study. Socioeconomic status was measured using highest parental education at the individual level and median income at the neighborhood (aggregated) level. Annual average outdoor concentrations of particulate matter with diameters <2.5 μm (PM2.5) and <10.0 μm (PM10), nitrogen dioxide (NO2), and black carbon (BC) in μg/m3 were estimated at the residential address. Mixed regression models were applied to examine the associations. Results Children from parents with a low education level were exposed to significantly higher levels of PM2.5, PM10, and BC compared to children from parents with a high education level. However, the associations were not significant when tested using regression models. Children who lived in areas with a lower median neighborhood income were exposed to significantly higher levels of air pollution; an interquartile range (IQR; €4505.00) decrease in income was associated with an increase in exposure to PM2.5 of 0.198 μg/m3, PM10 of 0.406 μg/m3, NO2 of 0.740 μg/m3, and BC of 0.063 μg/m3. Children of parents with a low/high education level had a higher exposure to PM2.5, PM10, NO2, and BC when living in a low income neighborhood. Exposure to all air pollutants was the highest for low parental education level and low neighborhood income. Conclusions: Low neighborhood income was significantly associated with higher levels of air pollution, while parental education level was not significantly associated. Children from parents with a low education and low income were exposed to the highest levels of air pollution.

Are there diminishing returns to social spending? Social policy, health and health inequalities in European countries. A comparative longitudinal survey data analysis

NORDHEIM, O. ET VAN DER WEL, K. A.

2025

Social Science & Medicine 380: 117721.

https://doi.org/10.1016/j.socscimed.2025.117721

This paper revisits the relationship between welfare arrangements and health (inequality) considerations. We examine whether specific welfare arrangements improve health and reduce health inequalities and if these effects diminish at higher levels of social protection. Our analyses of general self-rated health focuses on eight social spending categories and total social spending, using Eurostat data and statistical modelling techniques that distinguish between cross-sectional and longitudinal (within and between-country) effects, addressing unobserved country-level heterogeneity. Results from multilevel logistic regression analyses of 321,404 individuals within 28 countries in the European Social Survey (2002–2016) support the hypothesis that social policy matters for health and health inequality, particularly through large and inclusive programs like Old Age, Health, and Unemployment. Between-country variation in social spending was more consistently linked to health (inequality) than were within-country changes, as the latter may need longer timespans to materialise. The findings suggest a curvilinear relationship, where spending is most effective at lower levels. The paper concludes that welfare states can improve health and reduce health inequalities, especially in less developed welfare states through broad and inclusive programs.

Healthcare services for low-wage migrant workers: A systematic review

RAST, E., LAU, K., LIN, R. C., *et al.*

2025

Social Science & Medicine 380: 118176.

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Low-wage labour migrants often face health-damaging living and working conditions, but are frequently excluded from healthcare. The othering of migrants, bordering of healthcare and simple oversight and negligence create widening health inequalities for a society's essential workers. This review aimed to identify the forms and effectiveness of healthcare services designed to make healthcare accessible for migrant workers. We searched for literature through Medline, Embase, Global Health, Web of Science, and Global Index Medicus (from 1 January 2000 till 9 June 2023), focussing on selected work sectors (domestic work, construction, manufacturing, agriculture, mining). Primary research, reports, and grey literature from 2000 onwards containing descriptions or evaluations of healthcare services exclusively targeting low-wage migrant workers and their families were included. We excluded services focussing only on specific health conditions or disease screening. Quality appraisal was based on tools from the Joanna Briggs Institute. We narratively synthesised service characteristics and effects. This review follows the PRISMA reporting guidelines for systematic reviews and is registered with PROSPERO (XX). Identified studies included 21 healthcare services targeting low-wage migrant workers in six countries (China, Dominican Republic, Italy, Qatar, South Africa, USA) in three sectors (agriculture, manufacturing, domestic work). Services included established medical facilities (e.g., general hospital care, semi-permanent primary healthcare (PHC) services); mobile clinics for PHC; and telehealth services. The healthcare services were provided by governmental, non-governmental, academic, and private actors. Most targeted migrant farmworkers and were primarily located in the United States. Common healthcare barriers were addressed, for example, via free care, outreach, or non-traditional hours. However, service effects on health, access and uptake, patient satisfaction, and acceptability were largely unclear, as only six studies offered some fragmentary evaluative evidence. Few healthcare services targeting migrant workers have been documented and evaluated, especially in LMICs. Although migrant workers are deemed to be mobile populations, once in the destination location, many are quite immobile when it comes to accessing healthcare. Thus, in the face of persistent exclusion of migrant workers, health systems cannot simply rely on the ability of this vital workforce to seek and use preventative or curative care, but healthcare services must be actively designed to be accessible to this mobile population in order to ensure health as a human right.

The effect of the 'Every Mind Matters' campaign on mental health literacy: the moderating roles of socioeconomic status and ethnicity

RONALDSON, A., CHUA, K. C., HAHN, J., *et al.*

2025

European Journal of Public Health 35(2): 366-372.

https://doi.org/10.1093/eurpub/ckaf020

We previously reported short-lived improvements in mental health literacy following the Every Mind Matters campaign, followed by a return to baseline levels. In this study, we aimed to examine whether either socioeconomic status or ethnicity moderated these improvements. We conducted regression analyses on a nationally representative, repeated cross-sectional dataset of nine survey waves from September 2019 to March 2022. Interaction terms (ethnicity*wave, socioeconomic status*wave) were entered into regression models to assess the moderating effect of these variables. Where significant interactions emerged, we obtained marginal estimates and plotted them for ease of interpretation. We found no evidence that improvements seen in mental health literacy following the launch of Every Mind Matters were moderated by ethnicity or socioeconomic status. Over time, there was some evidence of lower scores relating to symptoms recognition, knowledge of actions to improve mental health, and desire for social distance (stigma) among adults of lower socioeconomic status, which converged again for symptom recognition. These findings suggest that while a web resource can empower people and improve mental health literacy, in relation to ethnicity and socioeconomic status, it may be that while this can avoid a widening of inequalities it is insufficient to lead to a narrowing of them.

Gender Affirming Medical Care Access: The Role of Healthcare Stereotype Threat and Social Support in a National Probability Sample of Transgender Adults

SMITH-JOHNSON, M. ET ALEXANDER, K.

2025

Social Science & Medicine 373: 118014.

https://doi.org/10.1016/j.socscimed.2025.118014

Transgender adults face persistent barriers to gender-affirming medical care (GAC)—medical interventions related to a person's gender expression. Extensive qualitative research suggests that accessing GAC is stressful partly because of anticipated stigma from providers and healthcare systems, but that social support from loved ones helps trans adults persist in seeking care. We know less about how anticipated stigma and social support relate to GAC access at the population level. This study utilizes a nationally representative sample of trans adults who want GAC

(N=204) from the U.S. Transgender Population Health Survey (2016-2018). We ask whether anticipated stigma in healthcare (operationalized as healthcare stereotype threat (HCST), or the worry a person has about being judged, mistreated, or stereotyped by providers because of their gender identity or sexual orientation) and perceived social support are associated with GAC utilization for trans adults. We find a significant positive relationship between GAC utilization, HCST, global social support, and significant other support. We also find a significant interaction between HCST and social support where greater HCST is only associated with greater GAC utilization at high levels of social support. These findings underscore the importance of social relationships like peer advocates and chosen families in supporting necessary medical care for trans adults who want it and the importance of increasing culturally competent care in healthcare settings for gender-diverse people.

Early-life access to primary healthcare and educational attainment: Evidence from community health centers in China

SUN, Y., LI, J., SHEN, X., *et al.*
2025
Social Science & Medicine 380: 118197.
https://doi.org/10.1016/j.socscimed.2025.118197

This paper uses the rollout of community health centers (CHCs) from the 1950s to the 1970s in China to study the long-term effects of early-life access to primary healthcare on educational attainment. By leveraging the variation across birth cohorts and communities in the establishment of CHCs, we find that exposure to CHCs in early life significantly increases children's completed years of education in later life. Event study estimates confirm that the beneficial effects of CHC exposure are concentrated in early life. Mechanism analysis reveals that early-life exposure to CHCs improves birth health and childhood health. The results remain robust after considering a series of robustness checks, such as ruling out confounding factors and placebo tests. Our findings underscore the significance of early-life primary healthcare in building human capital and indicate that the returns on accessing primary healthcare may be significantly underestimated.

Médicaments

Pharmaceuticals

Price regulation and competition among on-patent anticancer drugs in Italy

CAIMMI, M., CANALI, B., CANDELORA, L., *et al.*
2025
Health Policy 157: 105348.
https://doi.org/10.1016/j.healthpol.2025.105348

In recent years, the Italian Medicines Agency has adopted several measures aimed at curbing public pharmaceutical expenditure, including temporary and confidential price reductions, and Managed Entry Agreements. Besides, the Agency plays a pivotal role in price negotiations, serving as a tool for cost containment and financial sustainability for the Italian NHS. Our study aims at testing one potentially relevant channel for pursuing this objective and analyze if the Agency anchors the treatment cost of on-patent market entrants with those of on-patent therapeutic alternatives that previously obtained reimbursement in a given market. Our sample includes 86 anticancer indications which obtained reimbursement in Italy between March 2017 and May 2022, whose marketing authorization was granted under the centralized procedure at European level. Gathering data from multiple sources (drugs Summary of Product Characteristics, their pivotal clinical trials, and an IQVIA database on Italian negotiation dynamics), we identify competing indications within cancer site and treatment line, and then evaluate treatment costs based on median exposure to treatment in pivotal clinical trials. We retrieve prices from hospital expenditure data, which reflect discount negotiated with the regulator, tender, and commercial discounts. Our findings suggest that both the market average and the last reimbursed treatment cost significantly correlate with newly negotiated treatment costs, indicating that earlier negotiation outcomes serve as benchmarks for new ones.

Early access to medicines with added therapeutic value: Measuring and comparing time to medicines access in England, France, Germany, Italy and Spain

DELCROIX-LOPES, S., AMER, N., CHAIGNOT, C., *et al.*

2025

Health Policy 157: 105317.

https://doi.org/10.1016/j.healthpol.2025.105317

The scientific breakthroughs over the past few decades have opened up new therapeutic possibilities, transforming the treatment of critical illnesses like cancer and rare diseases. However, delayed access to these innovations can lead to a loss of valuable life years for patients. The annual European medicines access times Monitor, launched by the French Statutory Health Insurance (CNAM) with the support of the French National Authority for Health (HAS), analysed time to patient access across five countries between 2017 and 2023 (England, France, Germany, Italy and Spain) for a sample of 50 molecules that demonstrate therapeutic improvement. The results underscore the crucial role of Early Access Schemes-EAS in accelerating patient access to medicines. These schemes are particularly prevalent in countries where national reimbursement is contingent on Health Technology Assessment-HTA assessments and price negotiations—notably France, Italy, and Spain. These findings indicate that early access schemes, rather than being restricted to compassionate use for patients with no alternative treatment options, can also serve as a strategy to expedite access to essential therapies, particularly cancer drugs, prior to their formal reimbursement.

Identifying the most effective policies for minimising inappropriate use of antibiotics: A replicability study using three WHO datasets

HOLLOWAY, K. A. ET HENRY, D.

2025

Health Policy 155: 105269.

https://doi.org/10.1016/j.healthpol.2025.105269

Background Policy implementation to reduce overuse of antibiotics remains weak in many low/middle-income countries (LMIC). Aim Identify the most effective policies for reducing inappropriate use of antibiotics. Methods Data on four standard indicators of antibiotic use (lower values indicating less inappropriate use) from surveys (2006–12) and implementation of 23 policies (2007–11) were analysed. Differences in indicator scores between countries implementing and not implementing policies were calculated. The impacts of multiple policies were assessed by regression analysis. Results were combined with two previous studies, one using global data 2003–7, the other South-East Asia data 2010–2015. Results Data were available for 44 countries. Beneficial effects were seen in several analyses showing more active policy implementation was associated with lower antibiotic use. The number of effective policies were negatively correlated with % patients prescribed antibiotics (r -0.5, p = 0.002) and % upper respiratory tract infections prescribed antibiotics (r -0.6, p = 0.002). Correlation of average policy ranking effectiveness between this study and the earlier global study was significant (r 0.69, p < 0.001). The top six policies from average rankings across the three studies were: national body responsible for quality use of medicines; public education programs; undergraduate training of doctors on clinical guidelines; antibiotics unavailable without prescription; hospital drug and therapeutics committees; and medicines free at the point of care. Conclusion Essential medicines policies consistently found to be associated with lower antibiotic use should be implemented urgently.

Time to completion of conditions required by Health Canada after approving new drugs: a cohort study

LEXCHIN, J.

2025

Health Policy 155: 105314.

https://doi.org/10.1016/j.healthpol.2025.105314

Background To ensure that promising drugs for serious illnesses reach Canadians in a timely manner, Health Canada can approve them conditionally provided companies commit to conducting confirmatory studies to verify the benefits. Objective To determine how long it takes until the conditions are fulfilled and if certain factors affect that length of time. Methods A list of conditional approvals for new drugs and new indications for existing drugs to the end of 2024 was compiled from Health Canada databases. Orphan drug status was determined from the US Food and Drug Administration databases. Kaplan-Meier survival curves were constructed to determine how long it took to complete the studies. Results There were 153 conditional approvals: 91 were fulfilled, 45 have not been fulfilled as of January 18, 2025 and 17 were withdrawn. The median time for fulfillment was 1200 (IQR 777, 1852) days. Orphan drug status and whether the conditional approval was for a new drug or a new indication for an existing drug did not affect the time to completion. Conclusions Some NOC/c take considerable time to be fulfilled. Health Canada should require studies to be underway at the time that a NOC/c is granted except in exceptional circumstances and it should be transparent about the completion date for confirmatory studies and provided detailed reports about any delays. In the case of delays that cannot be justified it should be given the power to impose significant financial penalties on manufacturers through the NOC/c pathway being converted from a policy into legislation.

Promoting outpatient medication safety in Finland: A mid-term review of a national medication safety programme for community pharmacies (2021–2026)

MAKINEN, E., KOSKENKORVA, T., HOLMSTROM, A. R., *et al.*

2025

Health Policy 155: 105285.

https://doi.org/10.1016/j.healthpol.2025.105285

Pharmacotherapies are common therapeutic interventions in patient care. Despite most medications being self-managed by patients at home, little attention has been paid to medication risks in the outpatient medication management process. As community pharmacies dispense medicines to outpatients, they are well-positioned to decrease preventable harm by implementing systemic medication risk management practices. This article is a mid-term review of a national development programme to enhance community pharmacies' involvement in outpatient medication risk management in Finland (Valo programme 2021–2026). The article comprises the programme description utilising the US Centers for Disease Control and Prevention's framework, and the programme's preliminary mid-term results. Through the programme: 1) the same patient safety incident reporting and learning system used by most Finnish health- and social care (HSC) organisations was implemented in community pharmacies, 2) medication safety culture was promoted by enhancing community pharmacists' competencies in medication safety, 3) regional collaboration between community pharmacies and HSC organisations was supported through networks, and 4) a national research strategy was created to support outpatient medication safety research. Involving community pharmacies in outpatient medication risk management supports HSC systems. This article introduces nationwide actions that could be utilised in other countries to enhance community pharmacies' involvement.

Polysubstance Use Profiles Among the General Adult Population, United States, 2022

ROCKHILL, K. M., BLACK, J. C., IWANICKI, J., *et al.*

2025

American Journal of Public Health 115(5): 747-757.

https://doi.org/10.2105/ajph.2024.307979

Objectives. To characterize present-day polysubstance use patterns in the general adult population. Methods. From a 2022 nationally representative survey in the United States, we defined polysubstance use as last 12-month use of 2 or more drugs (n = 15 800). Latent class analyses included medical (as indicated) and nonmedical (not as directed) use of prescription opioids, stimulants, benzodiazepines, and antidepressants; recreational use of cannabis, psilocybin or mushrooms, other psychedelics, cocaine, methamphetamine, and illicit opioids; and concomitant use with alcohol, cannabis, prescriptions, or recreational drugs. Results. The national prevalence of polysubstance use was 20.9% (95% confidence interval = 20.5%, 21.3%), broken down into the following 4 latent classes: (1) medically guided polysubstance use (11.5% prevalence, 6.1% substance use disorder [SUD]): prescribed drug use, some cannabis, and no concomitant use; (2) principal cannabis use variety (4.0% prevalence, 31.9% SUD): high probability of cannabis use with various drugs concomitantly used; (3) self-guided polysubstance use (3.4% prevalence, 14.5% SUD): nonmedical use of prescriptions and concomitant use; and (4) indiscriminate coexposures (2.1% prevalence, 58.9% SUD): concomitant drug use with indiscriminate drug preference. Conclusions. Different polysubstance profiles show adults with untreated SUDs, and there are 2 previously unrecognized classes. Prevention and treatment strategies addressing polysubstance use should take a personalized perspective and tailor to individuals' use profile. (Am J Public Health. 2025;115(5):747–757. https://doi.org/10.2105/AJPH.2024.307979)

Copayments for Prescription Drugs: The Drivers of Demand Responses

VERHO, J. ET HARJU, J.

2025

Health Economics 34(6): 1160-1170.

https://doi.org/10.1002/hec.4955

ABSTRACT We study the demand responses of the drug copayment threshold in Finland using detailed prescription drug purchase data. The analysis reveals that the average drug costs increase discontinuously by 17% at the threshold above which out-of-pocket drug costs decrease substantially. Our results suggest an average price elasticity of –0.17, which indicates evident moral hazard costs. Approximately 80% of the overall effect is due to individuals buying drugs in larger quantities rather than purchasing higher-priced drugs. The heterogeneity analysis suggests that the responses are largest for drug categories taken on an as-needed rather than a regular basis.

Méthodologie – Statistique

Methodology – Statistics

The validation of the Needs Examination, Evaluation, and Dissemination assessment framework within the European Union: a modified Delphi study

CLAERMAN, R., KOHN, L., LEVY, M., *et al.*

2025

European Journal of Public Health 35(2): 228-234.

https://doi.org/10.1093/eurpub/ckaf027

The NEED (Needs Examination, Evaluation, and Dissemination) assessment framework was designed to identify and measure unmet health-related needs of patients and society across various health conditions, aiding the development of needs-driven healthcare policy and innovation. The framework consists of 25 needs criteria and 46 associated indicators that assess whether these needs are met or not. This study aims to validate the framework at the European Union (EU) level using a modified Delphi approach. We selected national and European institutes for the Delphi process based on their roles in public health, health technology assessment (HTA), medicine authorization, pricing and reimbursement (P&R), and patient advocacy. Using a modified Delphi approach, experts provided feedback on the framework's structure (dimensions and domains), health-related needs criteria, and indicators. Two Delphi rounds were conducted via online questionnaires. A panel of 26 experts participated in both rounds of the study. The majority of the participants reported expertise in HTA (50%) and P&R (15%), followed by patient advocacy (15%) and public health (8%). Seventeen EU Member States were represented, with a higher representation of experts from Belgium (12%) and Germany (12%). The NEED framework based on expert consensus consists of 4 dimensions, 3 domains, 24 criteria, and 43 indicators. The modified Delphi technique proved effective for validating the NEED framework at the EU level. This marks a critical first step toward consensus on defining and identifying unmet health-related needs, paving the way for a more needs-driven healthcare policy and innovation landscape.

The impact of reminders on representativeness and survey estimates among web-mode invited in the Danish National Health Survey

JEZEK, A. H., EKHOLM, O., THYGESEN, L. C., *et al.*

2025

European Journal of Public Health 35(2): 256-262.

https://doi.org/10.1093/eurpub/ckae176

Declining response proportions in health surveys may lead to increased non-response bias. Multiple reminders are often used to increase response proportions, and, thus, we aimed to determine if the use of reminders decreased the magnitude of non-response bias among web-mode invited in the Danish National Health Survey 2023. In the Danish National Health Survey 2023, a national random sample of 23 467 individuals (aged ≥16 years) with residence in Denmark were invited by a secure electronic mail service. Invited individuals received up to five inquiries: (i) web invitation, (ii) web reminder, (iii) paper invitation including a questionnaire and a prepaid return envelope, (iv) paper reminder, and (v) paper reminder including a questionnaire and a prepaid return envelope. The cumulative response proportions after first-, second-, third-, fourth-, and fifth inquiries were 19.1%, 28.9%, 37.2%, 39.3%, and 42.0%, respectively. In general, third, fourth, and fifth mailing respondents were more often men, at younger ages, with non-Western backgrounds, and unmarried compared to first mailing respondents. Furthermore, third, fourth, and fifth mailing respondents were in general found to have less favorable health behavior than first mailing respondents, but also a lower prevalence of fair or poor self-rated health and long-standing health problems. In conlusion, reminders are an effective way to increase the response proportion. Furthermore, the use of reminders was found to decrease the magnitude of non-response bias; however, the decrease was small due to the low number of individuals responding after fourth and fifth inquiries.

Patient Decisional Preferences: A Systematic Review of Instruments Used to Determine Patients' Preferred Role in Decision-Making

NESHAN, M., PADMANABAN, V., FAREED, N., *et al.*
2025

Medical Care Research and Review 82(3): 225-239.
https://doi.org/10.1177/10775587251316917

Decision control preferences (DCPs) refer to the degree of control patients' desire over their medical treatment. Several validated tools exist to evaluate a patient's DCPs, yet there is no universally used instrument and their use in clinical settings is lacking. We provide a systematic comparative summary of available DCP tools. Following a systematic database search, English language studies across medical contexts and patient populations were eligible if a validated assessment tool to evaluate patient DCPs was reported. Among the 15 tools that met inclusion criteria, the autonomy preference index (API) and the control preference scale (CPS) were the most used tools (API: 40%, CPS: 26.6%). Most studies (n = 9) sought to identify the information-seeking preferences of patients as a critical component of decision-making. Only few studies evaluated providers' perceptions of patient preferences. Considering the variety of patients' DCPs, implementation of DCP tools can optimize shared decision-making and improve patient outcomes.

Conceptualisation and Measurement of Healthy Ageing: Insights from a Systematic Literature Review

PIRIU, A. A., BUFALI, M. V., CAPPELLARO, G., *et al.*
2025

Social Science & Medicine 374: 117933.
https://doi.org/10.1016/j.socscimed.2025.117933

This paper enhances the understanding and measurement of Healthy Ageing (HA) through a systematic review of its multidimensional operationalisation. Despite progress in HA research, no consensus exists on its constitutive elements, and current frameworks often do not capture its full complexity. Building on the World Health Organization (WHO) HA definition, we organise empirical evidence under three dimensions: intrinsic capacity (IC), functional ability (FA) and the environment (ENV). To identify conceptual, empirical and methodological gaps, we provide a structured synthesis of concepts, measures and instruments used in HA research, evaluating methodological advancement and standardisation in HA measurement. Following PRISMA guidelines, we extract data from 55 quantitative, qualitative and mixed-method studies with a multidimensional HA focus. We arrange evidence into three primary domains (IC, FA and ENV; first order), 15 sub-domains (second order) and 84 themes (third order). We identify operational categories via thematic analysis and inductively determine the final categorisation, moving from third to first order based on conceptual and measurement considerations. Given the lack of systematic knowledge on ENV, we generate a more nuanced categorisation capturing different levels of analysis and contexts. We compute a mean usage ratio to assess differences in the application of validated tools across HA aspects. The review revealed substantial variability in HA conceptualisation and measurement. IC and FA are the most extensively studied domains, with well-established measurement approaches and widespread use. Common themes include locomotion, cognitive capacities and functional status. ENV remains significantly underexplored and lacks standardised measurement, as mainstream assessments still prioritise deficit-based approaches over enabling environments. This analysis calls for a standardised, multidimensional HA model integrating individual and contextual factors, recognising the role of structural environmental supports in shaping ageing trajectories. Future research should prioritise comprehensive HA measurement and pursue an interdisciplinary approach bridging conceptual and methodological gaps to inform HA policies effectively.

Completeness and quality of comprehensive managed care data compared with fee-for-service data in national Medicaid claims from 2001 to 2019

SAMPLES, H., LLOYD, K., RYALI, R., *et al.*

2025

Health Services Research 60(3): e14429.

https://doi.org/10.1111/1475-6773.14429

Abstract Objective To evaluate the completeness and quality of Medicaid comprehensive managed care (CMC) data in national MAX/TAF research files. Study Setting and Design This observational study compared CMC with fee-for-service (FFS) enrollee data in 2001–2019 Medicaid MAX/TAF inpatient, outpatient, and pharmacy files. Completeness was assessed as the proportion of enrollees with any claim and mean claims per enrollee with any claim. Quality was assessed as the proportion of inpatient and outpatient claims with primary diagnosis and procedure codes and the proportion of prescription drug claims with fill dates, National Drug Codes (NDC), days supplied, and quantity dispensed. Acceptable ranges for each study measure were defined as the national FFS mean ± 2 standard deviations. Data Sources and Analytic Sample We analyzed secondary data on 45 states from 2001 to 2013 (MAX) and 50 states and DC from 2014 to 2019 (TAF). The sample included adults aged 18–64 with continuous calendar-year enrollment who were eligible for full Medicaid benefits and ineligible for Medicare. We determined CMC enrollment rates and assessed data completeness and quality among state-years with ≥10% CMC penetration, comparing CMC with FFS enrollees. Principal Findings Across 891 state-years, 194,364,647 enrollees met inclusion criteria. Of 540 state-years (60.6%) with ≥10% CMC enrollment, CMC data were largely comparable to national FFS distributions for all inpatient (n = 430; 79.6%), outpatient (n = 467, 86.5%), and prescription (n = 459, 85.0%) completeness criteria and for all inpatient (n = 449, 83.1%), outpatient (n = 511, 94.6%), and prescription (n = 528, 97.8%) quality criteria. Overall completeness (92.3%) and quality (84.6%) improved substantially by 2019. Conclusions Completeness and quality of CMC data were largely comparable to FFS data, with increasing state-years meeting criteria over time. Further research on national Medicaid populations should assess and address differences in data completeness and quality by plan type across states, over time, and in relation to specific study samples and measures of interest.

Politique de santé

Health Policy

From policy to practice: Rolling out the clinical nurse specialist role in Portugal

AMORIM-LOPES, M., CRUZ-GOMES, S., DOLDI, E., *et al.* 2025

Health Policy 155: 105308.

https://doi.org/10.1016/j.healthpol.2025.105308

The specialization of Health Human Resources (HHR) is increasingly recognized as essential for addressing evolving healthcare demands. This paper presents a comprehensive policy framework for assisting with the implementation of Clinical Nurse Specialist (CNS) roles at the national or regional level, integrating key dimensions including barriers and enablers, regulation and governance, education and training requirements, career development, workforce planning, and economic analysis. The framework was applied to the implementation of CNS roles in Portugal, resulting in the issuance of a decree-law by the government. Our findings demonstrate that the economic analysis step was critical in addressing concerns from government authorities and health system funders regarding the potential budgetary impact of CNS implementation. By providing evidence-based projections of costs and benefits, the economic analysis facilitated smoother negotiations and consensus-building among stakeholders, including nursing unions. Furthermore, the integration of workforce planning ensured the alignment of educational capacity with workforce needs, thus avoiding potential implementation bottlenecks. The application of the framework also revealed important feedback relationships between its dimensions, highlighting the interdependent nature of the implementation process. This dynamic approach, which adapts to real-time feedback and stakeholder input, underscores the necessity of a holistic and iterative strategy for successful CNS role integration. The insights gained from the Portuguese case underscore the utility of this policy framework in guiding the implementation of advanced nursing roles in diverse healthcare contexts.

Démocratie en santé et santé bucco-dentaire

DENIS, F., BRUN, C., WALGER, R., *et al.*

2025

Santé Publique vol. 37(2): 15-18.

https://doi.org/10.3917/spub.252.0015

La Conférence nationale de santé (CNS) est une instance consultative de démocratie en santé, placée auprès du ministre chargé de la santé. Après s'être autosaisie de la santé buccodentaire dans le cadre de son programme de travail, le Directeur général de la santé lui a demandé de lui remettre un rapport d'ici la fin 2024. Ces recommandations sont une synthèse de plus de 40 réunions de travail et 32 auditions réalisées sur une période de 9 mois. Parmi les recommandations emblématiques, nous insistons plus particulièrement sur le pilotage d'une possible feuille de route « buccodentaire » par un délégué interministériel. Que ce délégué puisse rendre compte des actions engagées auprès des instances de la CNS serait l'occasion inédite de renforcer le rôle de parlement de la santé de cette instance de démocratie en santé.

The second Trump administration: A policy analysis of challenges and opportunities for European health policymakers

GREER, S. L., JARMAN, H., KULIKOFF, R., *et al.*

2025

Health Policy 158: 105350.

https://doi.org/10.1016/j.healthpol.2025.105350

Background The second Trump administration has already made major changes in US policies that affect health and health systems worldwide. Methods We use the Health Systems Performance Assessment categories developed by the European Observatory on Health Systems and Policies to identify areas in which US actions affect the health systems and policies of European states and the EU, and presidential Executive Orders supplemented by campaign statements to understand US actions. Results We identify relevant US policies in the areas of finance, resource generation (regulation, vaccines, artificial intelligence, workforce, research, education) and governance (geopolitical turbulence, climate change, US departure from the World Health Organization, and foreign aid). We then identify opportunities for states or the EU to strengthen their health systems, potential threats that might arise to their health systems from US actions, and serious confirmed threats. Conclusion The second Trump administration is creating heavy demands on European governments in many areas, which might undermine their fiscal capacity and willingness to fund health systems or new ventures, but diminished US investment in areas such as multilateralism, pandemic response, research, education, and aid (especially in areas such as gender and reproductive health) all create opportunities for European policymakers to strengthen their health systems, health-related economic sectors, and influence in global health governance.

What gets measured in palliative care? A review and synthesis of routine data collection in 16 countries

HURLEY, E., MAY, P., MATTHEWS, S., *et al.*

2025

Health Policy OPEN 8: 100141.

https://doi.org/10.1016/j.hpopen.2025.100141

Background There is an increasing focus on strengthening palliative care data infrastructure to evaluate and improve the quality of care. We conducted an extensive review of policy documents to identify international best practice in the use of routine data in palliative care. Methods We identified 16 countries with well-established palliative care services before undertaking the review. We searched systematically for relevant documentation on each country in the academic, grey and governmental literature. For each country we then compiled a narrative synthesis utilising a standardised extraction template. Local experts verified country-level synopses. We combined the 16 country documents using thematic synthesis. Results There was significant heterogeneity in the data infrastructure of the countries examined. The majority of the databases and data sources focused on specialist palliative care services with a notable lack of data on palliative care delivered in primary and community care. Several countries have established bespoke palliative care databases; others harness existing data sources, and capitalise on the existence of unique patient identifiers. The gaps and limitations identified were commonly shared across all types of palliative and end of life care data infrastructure. Similarly, many of the factors deemed highly influential in implementing and sustaining existing databases are relevant across all data infrastructure. Conclusions This first-of-its-kind analysis details the characteristics of databases/data sources and highlights the significant heterogeneity which exists. The strengths and limitations of existing databases/data sources and the factors that influence how well these systems are sustained are examined, providing key learnings for those eager to improve the data infrastructure in their own jurisdictions.

▶ Passing Policies That Promote Urban Health: Lessons From the CityHealth Project

JERNIGAN, D. H., FORREST, K., PATTERSON, C., *et al.*

2025

American Journal of Public Health 115(6): 864-867.

https://doi.org/10.2105/ajph.2025.308036

Cities are important laboratories for cross-sectoral collaboration and advancing equity. CityHealth, a project of the de Beaumont Foundation and Kaiser Permanente, used legal epidemiology to identify, score, and promote nine city-level policies important to population health in the 40 largest US cities from 2017 to 2021. The project supported 86 policy changes over five years. These results demonstrate possibilities for encouraging passage of city-level health-enhancing policies and the need to move beyond scoring and ranking to direct policy advocacy. (Am J Public Health. Published online ahead of print April 10, 2025:e1–e4. https://doi.org/10.2105/AJPH.2025.308036)

▶ Global health and care worker migration requires a global response

KUHLMANN, E., FALKENBACH, M., CORREIA, T., *et al.*

2025

Health Policy 155: 105305.

https://doi.org/10.1016/j.healthpol.2025.105305

The global migration of the health and care workforce (HCWF) has intensified, leading to complex policy scenarios and diverse migration patterns. While the traditional narrative of individual health and care workers (HCWs) migrating from low- and middle-income countries to high-income countries in search of higher income, career prospects and working conditions remains relevant, it now coexists with many other drivers, incentives, and dynamics at individual and policy level. The evolving dynamics of HCW migration have profound implications extending far beyond health labour markets, influencing broader societal and political landscapes. Despite their significance, the qualitative shifts in HCWF migration patterns and the governance challenges they present are poorly understood and under-researched, and policies have thus been limited in their effectiveness. In this policy comment we argue for a global response and an enhanced focus on policy implementation, using selected case studies to illustrate the argument. The cases highlight complexities of HCW migration patterns and opportunities for strengthening implementation of the WHO Global Code of Practice to respond effectively to the diverse needs of health systems and individual HCWs.

▶ Disparities in the organisation of national healthcare systems for treatment of patients with psoriatic arthritis and axial spondyloarthritis across Europe

MICHELSEN, B., OSTERGAARD, M., NISSEN, M. J., *et al.*

2025

Health Policy 156: 105311.

https://doi.org/10.1016/j.healthpol.2025.105311

Background Studies on national policies for biologics are warranted. Objectives To map and compare national healthcare set-ups for prescription, start, switch, tapering, and discontinuation of biologic/targeted synthetic disease-modifying antirheumatic drugs (DMARDs) in patients with psoriatic arthritis and axial spondyloarthritis across Europe, and assess the healthcare set-ups in relation to countries' socio-economic status. Methods An electronic survey was developed to collect and compare information on national healthcare systems. The relationship between the cumulative score of biologic/targeted synthetic DMARD regulations, socioeconomic indices, and biologic originator costs were assessed by linear regression. Results National healthcare set-ups differed considerably across the 15 countries, with significantly fewer regulations with increasing socioeconomic status measured by GDP/current health expenditure/human development index, and with increasing biologic originator costs. In most countries, the biologic/targeted synthetic DMARD prescribing doctor was required to adhere to country and/or hospital recommendations, and about a third of countries had a national/regional tender process. Prescription regulations for biologic/

targeted synthetic DMARDs, including pre-treatment and disease activity requirements, varied substantially. Approximately a third of countries had criteria for discontinuation and tapering, whereas only few had for switching. Notably, two countries disallowed biologic/targeted synthetic DMARD retrials, and one imposed limit on the maximum number of biologic/targeted synthetic DMARDs permitted. Conclusion The findings highlight substantial variability in healthcare set-ups for biologic/targeted synthetic DMARD use in psoriatic arthritis and axial spondyloarthritis across Europe and their association with socioeconomic status and drug costs. These insights provide a basis for rheumatology societies, policymakers, and stakeholders to evaluate and potentially optimize healthcare policies.

Politique sociale

Social Policy

▶ Understanding, Assessing, and Improving Social Health Resource Referrals in Healthcare Organizations

GARCIA, S., MAHMUD, A., DUMKE, K., *et al.*

2025

Health Services Research 60 Suppl 3(n/a): e14466.

https://doi.org/10.1111/1475-6773.14466

ABSTRACT Objective To describe and assess the utility and accuracy of Kaiser Permanente's self-service social service resource locator (SSRL), a community resource directory that can be integrated with electronic health records, using a modified asset mapping approach. Study Setting and Design We identified, described, and visualized the number and types of food insecurity resources within five miles of a large primary care clinic in Washington state. Data Sources and Analytic Sample Analyses relied on (1) neighborhood and patient-level food insecurity data, (2) patient surveys and interviews, (3) SSRL abstraction, and (4) in-person walking assessment with qualitative coding of site photographs. Means and mean percentages of food insecurity were calculated and mapped for the US, WA state, and counties. Qualitative interviews were coded and analyzed using a rapid templated approach. For the SSRL, we abstracted the number and types of food resources, and the comprehensiveness of information in the database. Photographs of resource locations identified in Kaiser Permanente's database were coded for environmental barriers and facilitators. Principal Findings Common barriers to accessing social services included eligibility criteria, a mismatch of services, or a lack of capacity among organizations. Of the 18 resources identified from the SSRL, 12 listed some eligibility criteria, and of 10 requiring an application, only three provided a hyperlink. In the walking assessment, five resources did not match their listing online or were unavailable. Conclusions Modified asset mapping methods with existing data sources may be a pragmatic approach to understanding social needs, social health resources, and the patient experience of connecting with them. Inaccurate and inadequate information is a significant barrier to SSRL effectiveness. Improving the real-time accuracy of resource availability and eligibility in SSRL databases and filtering functionality is critical to ensuring successful resource connection.

Prévention

Prevention

Social Connections and COVID19 Vaccination

BASU, A. K., CHAU, N. H. ET FIRSIN, O.

2025

Health Economics 34(6).

https://doi.org/10.1002/hec.4953

ABSTRACT This paper unpacks the effects of social networks on county-level COVID19 vaccinations in the US. We jointly assess the contemporaneous and dynamic network effects of vaccination exposure, to distinguish between network-mediated contemporaneous effects (e.g., "vaccine-hunter" Facebook groups crowd-source information about access and efficacy) and longer-term effects (e.g., vaccine exposure chips away vaccine hesitancy). Accounting for possible correlated shocks, socio-economic/spatial confounders, and pandemic-related shifters, we find positive stage-of-pandemic dependent contemporaneous friendship network effects, and null dynamic network effect, thus sharply distinguishing COVID19 vaccination from other infection-mitigating practices in terms of openness to social-learning over time.

Quick buys for prevention and control of noncommunicable diseases

GALEA, G., EKBERG, A. ET CIOBANU, A.

2025

The Lancet Regional Health – Europe 52: 101281.

https://doi.org/10.1016/j.lanepe.2025.101281

Despite their established effectiveness, uptake of the WHO best buys for tackling non-communicable diseases (NCDs) has been uneven and disappointing. Here we introduce the "quick buys", an evidence-based set of cost-effective interventions with measurable public health impacts within five years. We reviewed 49 interventions previously established as cost-effective (<$I20,000 per disability-adjusted life-year averted) to identify the earliest possible detectable effect on high-level population health targets. Using a strict evidence hierarchy, including Cochrane and systematic reviews, we estimated the effects of each intervention against global targets agreed upon by countries. Quick buys were defined as those interventions that could exhibit measurable effects within 5 years, aligning with average electoral cycles in across the WHO European Region. Of the 49 interventions, 25 qualified as quick buys, including those relating to tobacco (n = 5), alcohol (n = 4), unhealthy diet (n = 3), physical inactivity (n = 1), cardiovascular disease (n = 3), diabetes (n = 4), chronic respiratory disease (n = 1), and cancer (n = 4). These findings not only offer guidance to policymakers deciding on interventions that align with short-term political cycles but also have the potential to accelerate progress to global health targets, particularly the 2030 Sustainable Development Goal of reducing premature NCD mortality by one-third.

« Prise en compte des preuves scientifiques dans les actions de prévention et promotion de la santé » : l'IGAS soutient un modèle loin des réalités de la promotion de la santé

LOMBRAIL, P., NAIDITCH, M. ET FERRON, C.

2025

Santé Publique vol. 37(2): 9-13.

https://doi.org/10.3917/spub.252.0009

L'IGAS a publié un rapport sur la « prise en compte des preuves scientifiques dans les actions de prévention et promotion de la santé ». Ce rapport véhicule une approche comportementaliste empreinte de socioparésie. Nous le discutons aux motifs suivants : une définition problématique du champ « prévention et promotion de la santé », une prise en compte trop exclusive des preuves scientifiques dans ce champ, une place déséquilibrée de la recherche par rapport à l'expertise, le choix d'une approche comportementale conduisant à minorer les enjeux de l'équité en santé.

Hésitation vaccinale des étudiants en santé : une revue de littérature

LUYT, D., STITI, K., VALTER, R., *et al.*

2025

Santé Publique vol. 37(2): 57-71.

https://doi.org/10.3917/spub.252.0057

Introduction : La vaccination parmi les professionnels de la santé, y compris ceux en formation, se révèle cruciale pour la protection des populations, notamment face aux risques infectieux émergents. Les étudiants en santé constituent une population potentiellement exposée aux virus, avec le potentiel de les transmettre, tout en jouant un rôle majeur en tant que futurs prescripteurs. Malgré leur importance, il existe peu d'études sur l'hésitation vaccinale au sein de cette population. But de l'étude : L'objectif de cette revue de littérature est de rassembler, organiser et analyser les données existantes concernant l'hésitation vaccinale des étudiants en santé dans le monde et les facteurs qui y sont associés. Résultats : Dix-neuf articles ont été inclus dans l'analyse. La définition retenue pour l'hésitation vaccinale était non consensuelle. Selon les études, les estimations de l'hésitation vaccinale des étudiants en santé, toutes vaccinations confondues, s'étendaient de 6,7 % à 80,2 %. Un des principaux facteurs associés à l'hésitation vaccinale mis en évidence était le doute, la peur, l'inquiétude ou l'expression d'un manque de sécurité du vaccin avec la crainte des effets indésirables. Enfin, l'hésitation vaccinale dépendait fortement de la vaccination étudiée, elle était plus élevée pour les infections émergentes (COVID-19, grippe H1N1). Elle dépendait également du pays et de la filière d'étude. Conclusions : Pour aborder l'enjeu actuel de la vaccination des étudiants en santé, il est essentiel d'approfondir qualitativement l'hésitation vaccinale. Cela implique une exploration plus détaillée des contextes socio-culturels et professionnels liés à cette hésitation, ainsi qu'une description plus approfondie des enseignements associés à la vaccination par filières.

▶ Do nudges need a regulatory push? Comparing the effectiveness and implementation of exemplar nudge (size-based) and non-nudge (price-based) dietary interventions

MARTEAU, T. M., MANTZARI, E. ET HOLLANDS, G. J.

2025

Social Science & Medicine 373: 118004.

https://doi.org/10.1016/j.socscimed.2025.118004

Changing behaviour across populations is key to improving population health and achieving net zero by 2050, including changing diets. We examine the extent to which nudges, with the potential to contribute to such change, are being implemented alongside traditional approaches. We compare the effectiveness and extent of implementation into policy of two interventions to improve diets: size-based interventions that alter portion, package or tableware size, commonly considered a nudge; and, price-based interventions, including food-item taxes, not considered a nudge. We conducted four rapid reviews: two for systematic reviews with meta-analyses aimed to determine the effectiveness of size-based and price-based interventions, respectively; and two for reports to estimate the extent to which size-based and price-based interventions have been implemented in health or environment policies of governments, public authorities, or private sector organisations, at national or sub-national levels. Both sets of interventions were consistently found in research studies to be effective at reducing consumption and purchasing of unhealthy products, but price-based interventions have been implemented in policies far more often than size-based ones. At least 118 countries have implemented taxes on sugar sweetened beverages (SSBs), and 42 countries have implemented taxes on unhealthy foods. In contrast, we identified 20 reports of size-based interventions implemented at sub-national level, of which only one involved regulation. Explaining and reversing the lack of implementation of size-based interventions and other effective nudges merits prioritisation to help realise global ambitions to improve population health and achieve net zero by 2050.

Psychiatrie

Psychiatry

L’urgence psychiatrique préhospitalière : Un maillon essentiel de l’organisation des soins

ABGRALL, G.

2025

Gestions Hospitalières 2025(644): 167-170.

L’augmentation des besoins en soins psychiatriques se manifeste notamment par une hausse de 30% des passages pour motifs psychiatriques dans les services d’accueil des urgences (SAU). Insuffisamment équipés et sous-dotés en personnel spécialisé, les SAU se trouvent ainsi en difficulté, générant files d’attente et surcharge des box d’urgence. Face à cette situation, le préhospitalier joue un rôle crucial dans l’organisation graduée des soins, facilitant la création de filières spécialisées et apportant des réponses adaptées et rapides aux patients. Le pôle psychiatrique du Samu de Paris, en synergie avec l’ensemble de l’offre préhospitalière régionale et un réseau de professionnels de ville, a progressivement construit un écosystème complet. Il permet une meilleure fluidité de la prise en soins, une rationalisation des ressources et une adaptation des parcours de soins aux besoins spécifiques des patients.

Mental health and wellbeing priority setting: a study of evidence use in schools in England

ALLARD, C., JOHNSON, R., O’LOUGHLIN, S., *et al.*

2025

Social Science & Medicine 380: 118214.

https://doi.org/10.1016/j.socscimed.2025.118214

Educational settings represent an important site for mental health and wellbeing (MHWB) investment, with an upsurge in research evidence to support such investments. However, the way in which schools use evidence to support priority setting has not been widely documented. This article focuses on how, in practice, English schools use evidence in investing in MHWB initiatives. We conducted exploratory interviews and document analysis with decision-makers and stakeholders across four schools (two primary and two secondary). Five themes were derived to explain how school decision-makers select and use evidence (i) ‘context, needs, and ideology’; (ii) ‘internal and external data for self-management’; (iii) ‘experiences and expertise’; (iv) ‘evidence to inform and challenge’; and (v) ‘external social networks to access evidence’. The findings show the non-linear, interactive, role of evidence in schools, and how evidence is used via a ‘political model’, when decision-makers use research to back-up their position. Researchers seeking to inform resource allocation decisions in school settings may wish to work with interactive or political models of evidence use to increase the uptake of the evidence they generate.

La fabrique des politiques publiques

BELLIVIER, F.

2025

Gestions Hospitalières (644): 138-143.

La fabrique des politiques publiques dans de la champ de la santé mentale fait face à de nombreux défis dont celui de la fréquence des troubles et des coûts qu’ils engendrent mais également des défis organisationnels et de changement de culture. La France est engagée depuis quelques années dans une nouvelle phase de réformes de ses politiques de prévention, de soins et d’accompagnement des personnes porteuses d’un trouble psychique. Après un bref historique, cet article passe en revue les réformes engagées depuis 5 ans, en fait le bilan et propose des priorités d’action.

Rattrapons, en dix ans, le retard pris dans les formations des professionnels travaillant en psychiatrie

BERNARD, O. ET PASCAL, F.

2025

L’information psychiatrique 101(4): 211-213.

https://doi.org/10.1684/ipe.2025.2868

L’opinion publique est aujourd’hui sensibilisée au manque de moyens financiers et en personnel de la psychiatrie en France. Les professionnels savent de leur côté que leurs formations initiales et continues en psychiatrie sont insuffisantes. Commençons par les médecins qui n’ont pas de stage d’externe obligatoire en psychiatrie pendant leurs études et pas davantage pendant l’internat de médecine générale.

Crise de la psychiatrie en France : enjeux éthiques et urgence d'une réponse

CONSOLI, A., CROZIER, S. ET GZIL, F.
2025
Sève : les tribunes de la santé(83): 105-112.

La crise que connaît la psychiatrie est sans précédent, en France mais aussi dans d'autres pays européens. De très nombreux rapports ont souligné combien les difficultés d'accès aux soins et l'insuffisance des moyens pour prendre correctement en charge les personnes porteuses de troubles psychiatriques sont délétères pour ces personnes et leurs familles. Le CCNE souligne que celles-ci ont également de graves conséquences éthiques. Ainsi, il accueille avec satisfaction le fait que la santé mentale devrait être érigée comme « Grande cause nationale 2025 », de même que l'adoption par la Haute Autorité de santé d'un programme pluriannuel dédié à la santé mentale et à la psychiatrie pour la période 2025-20301. Néanmoins, compte tenu de l'urgence et de la gravité de la situation, il appelle plus spécifiquement à la mise en oeuvre d'un plan Psychiatrie, ambitieux et structurant, reposant sur trois objectifs prioritaires : garantir l'accès à des soins psychiatriques dignes ; lutter contre la stigmatisation ; et renforcer la formation et la recherche en psychiatrie. Cette mobilisation est essentielle, car il en va du respect des droits fondamentaux de personnes.

La psychiatrie de secteur

DELION, P.
2025
Sève : les tribunes de la santé (83): 37-45.

L'article présente la psychiatrie de secteur, son histoire et sa mise en pratique à partir des années 1970. La sectorisation en psychiatrie est la plus grande invention de la psychiatrie du XXe siècle. À la condition d'être entreprise à la lumière des concepts de la psychothérapie institutionnelle, ses dérives technobureaucratiques peuvent être aisément évitées. Elle reste aujourd'hui la forme la plus aboutie d'une psychiatrie démocratique au service de tous ceux qui en ont besoin, et il est regrettable que cette constatation de la plupart des praticiens expérimentés ne soit pas relayée par les gouvernants qui sont pourtant à la recherche, prétendent-ils, du meilleur système pour la population qui les a élus. Et incidemment, probablement celui qui semble le plus économique quant au rapport entre les crédits mis en jeu (néanmoins toujours inférieurs à ceux des autres spécialités) et les services rendus en termes d'humanité des soins et de santé publique. En outre, ce modèle présente un intérêt pour toutes les pathologies chroniques et il devrait inspirer les médecins, toutes spécialités confondues, qui sont amenés à prendre en charge à long terme les patients les plus gravement touchés.

Enjeux économiques liés à la santé mentale du point de vue de l'Assurance maladie (2015-2022)

EXPERT, A., DE LAGASNERIE, G. ET RACHAS, A.
2025
Sève : les tribunes de la santé (83): 69-88.

Cet article propose d'étudier tout d'abord la place de la santé mentale dans les dépenses de l'Assurance maladie, en comparaison avec d'autres grandes catégories de pathologies, en 2022 (dernières données disponibles) et entre 2015 et 2022. Ensuite, face à la diversité des troubles en lien avec la santé mentale, une description détaillée des différentes pathologies psychiatriques et traitements pris en charge est réalisée. Enfin, une analyse spécifique est présentée sur l'évolution préoccupante de la consommation de médicaments psychotropes chez les adolescents et jeunes adultes de 12 ans à 25 ans, entre 2015 et 2023.

La santé mentale en France en 2025 : tentons de sortir du brouillard

FALLISSARD, B.
2025
Sève : les tribunes de la santé (83): 47-56.

Il s'agit d'évaluer l'état actuel de la santé mentale en France en 2025, en mettant l'accent sur la prévalence de la dépression, des tentatives de suicide, et des suicides effectifs. On observe ainsi une augmentation de la dépressivité, en particulier depuis 2017, avec des variations importantes entre les sexes et les tranches d'âge. Les jeunes femmes montrent des taux de tentatives de suicide en hausse depuis 2020, chez les jeunes hommes la hausse est plus modeste. Dans les autres tranches d'âge cette augmentation ne semble pas exister. Parallèlement, les taux de suicide ont globalement diminué depuis le début du siècle, malgré une légère remontée récente chez les jeunes. Les données soulignent une dissociation entre les niveaux de dépressivité et les taux de suicide, suggérant que les deux ne sont pas directement corrélés.

Le juge et la politique de santé mentale

GARGOULLAUD, S.

2025

Sève : les tribunes de la santé(83): 117-129.

L'hospitalisation contrainte interroge les conditions de garantie d'un équilibre entre la nécessité des soins psychiatriques et le respect des libertés individuelles. Depuis 2013, la loi impose une intervention systématique du juge judiciaire pour contrôler les décisions administratives de soins psychiatriques sans consentement et autoriser la poursuite des hospitalisations complètes au-delà de douze jours puis tous les six mois. Intégré au code de la santé publique au titre de la politique de lutte contre les maladies mentales, ce contrôle demeure un défi quant à sa finalité, à sa nécessité et aux modalités de sa mise en œuvre.

La réforme du financement de la psychiatrie : une réforme de transition

GUIDONI, D.

2025

Sève : les tribunes de la santé (83): 89-94.

Le modèle de financement de la psychiatrie n'avait pas connu d'évolution depuis les années 1980. Il devenait donc urgent de commencer à réparer les inadéquations constatées dans l'allocation de ressources dans ce secteur. Mais la réforme doit aussi être vue avec modestie. Elle est une transition vers un modèle plus abouti qui pourra advenir grâce à une meilleure connaissance des pathologies et de leur traitement sur la durée.

Psychiatrie : réduire l'isolement et la contention. Un impératif éthique et organisationnel

GUISARD, K.

2025

Gestions Hospitalières 2025(644): 134-135.

Longtemps considérés comme des outils incontournables pour gérer les crises en psychiatrie, l'isolement et la contention sont aujourd'hui remis en question. Des initiatives émergent pour repenser les pratiques et privilégier des approches alternatives. Cet article explore les leviers concrets mobilisables pour une prise en charge plus respectueuse des droits des patients, sans compromettre la sécurité des soins. (R.A.)

Widening Disparities in All-Cause and Despair-Related Mortality Among Swedish Youths: Disentangling Selection and Causation

HOGBERG, B. ET SCARPA, S.

2025

Social Science & Medicine 377: 118130.

https://doi.org/10.1016/j.socscimed.2025.118130

Rising rates of «deaths of despair» – mortality from suicide, drug overdose, and alcohol-related causes – have contributed to widening educational disparities in mortality. It is not known to what extent the trends are due to selection effects (health causing education, or a third factor causing both) or social causation (education affecting health). This study investigated the relative contribution of selection and causation for these trends, focusing on the recently documented widening achievement-based disparities in mortality among Swedish youths. To this end, two cohorts of Swedish compulsory school graduates (graduating in 1992-1993 and 2009-2010, respectively) were followed for eight years after graduation using comprehensive administrative data (n=424,715). Logistic regression models were used to assess the role of pre-graduation selection, while inverse odds ratio-weighting was used to assess mediation by post-graduation socioeconomic disadvantages. Roughly half of the association between low achievement and all-cause and despair-related mortality within cohorts was due to selection. However, selection effects did not explain the widening disparities over time. Socioeconomic mediators accounted for most of the remaining disparities within cohorts as well as of for most of the increase in these disparities over time. Overall, social causation was more important than selection in explaining the widening educational disparities in all-cause and despair-related mortality. We conclude that low academic achievement increasingly constrains life-course prospects of Swedish youths, amplifying its adverse health consequences. These findings highlight the need for lower barriers in the education system and for viable educational and employment pathways for low-achieving students in an increasingly knowledge-intensive labor market.

Quelles urgences pour la psychiatrie ?

LEJOYEUX, M.

2025

Sève : les tribunes de la santé (83): 113-115.

La crise de la psychiatrie est presque aussi ancienne que l'existence de la psychiatrie. La discipline, à juste titre le plus souvent, se considère insuffisamment reconnue et valorisée. Ses actes sont moins visibles et moins socialement appréciés que ceux issus d'autres domaines de la médecine. Les malades psychiatriques suscitent pour partie de la méconnaissance (une maladie vue comme un manque de volonté, une tendance à se laisser aller), ou de l'inquiétude. La part de compassion et d'identification est moindre pour ces patients. Cette crise a aujourd'hui de multiples conséquences et appelle d'urgence réflexions et réformes.

▶ Social and mental health pathways to institutional trust: A cohort study

PAQUIN, V., MICONI, D., AVERSA, S., *et al.*

2025

Social Science & Medicine 379: 118199.

https://doi.org/10.1016/j.socscimed.2025.118199

Objective Trust in institutions such as the government is lower in the context of mental health problems and socio-economic disadvantage. However, the roles of structural inequality, interpersonal factors, and mental health on institutional trust remain unclear. This study aimed to examine the associations of social and mental health factors, from early life to adulthood, with institutional trust. Method Participants (n = 1347; 57.2 % female) were from the population-based Québec Longitudinal Study of Child Development (1997–2021). Trust in 13 institutions was self-reported at age 23. Predictors were 20 social and mental health factors during early life, adolescence, and adulthood. Associations were examined with linear regressions corrected for false discovery rate. Pathways were explored using the temporal Peter-Clark algorithm. Results Early-life factors associated with lower levels of trust were male sex, racialized minority status, low household income, and maternal history of depression and antisocial behaviors. After adjusting for early-life factors, adolescence factors associated with lower levels of trust were internalizing and externalizing problems, bullying exposure, and school difficulties. Independently of early-life or adolescence factors, adulthood factors associated with lower levels of trust were perceived stress, psychotic experiences, suicidal ideas, and seeking professional help, whereas greater social connectedness was associated with greater trust. Temporal Peter-Clark analyses identified social connectedness and psychotic experiences as potential proximal determinants of institutional trust. Conclusion This study identified factors related to structural inequality, interpersonal relationships, and mental health over development that were associated with institutional trust. Interventions aimed at promoting social connectedness and equity may improve institutional trust and wellbeing.

▶ Organisation des filières d'urgence psychiatriques : Vers une optimisation des dispositifs pour gérer la crise

POULET, E. ET GUILLEMET, P.

2025

Gestions Hospitalières 2025(644): 171-174.

L'augmentation des passages aux urgences psychiatriques, exacerbée par la crise sanitaire et les difficultés de la psychiatrie publique, souligne l'urgence d'une meilleure organisation des filières de prise en charge. Longtemps perçue comme un domaine à part dans la médecine d'urgence, la psychiatrie doit désormais être pensée en filière intégrée, du préhospitalier à la post-urgence. Les auteurs explorent ici les enjeux et leviers d'optimisation des dispositifs existants, afin de garantir une réponse rapide et adaptée aux besoins des patients tout en fluidifiant les parcours de soins.

▶ Santé mentale et psychiatrie : un engagement renouvelé de la Haute Autorité de santé pour les années 2025-2030

PRIGENT, A., LE BAIL, M. ET LANSIAUX, A.

2025

Seve : les tribunes de la sante(83): 57-68.

La Haute Autorité de santé (HAS) organise depuis 2013 ses travaux dans le champ de la santé mentale et de la psychiatrie sous la forme de programmes pluriannuels prospectifs et évolutifs, dans une démarche impliquant les associations d'usagers et de familles/proches, les organisations professionnelles, les fédérations d'établissements et les institutionnels. Elle se mobilise sur l'ensemble de ses missions, tournées vers la santé au sens le plus large : recommander les bonnes pratiques, sur différentes thématiques, telles que la santé mentale et la psychiatrie de l'enfant et de l'adolescent, les droits des patients et la sécurité en psychiatrie et les troubles du neurodéveloppement ; mesurer et améliorer la qualité, y compris dans les établissements autorisés en psychiatrie, par le biais de la mesure d'indicateurs de qualité et de sécurité des soins (IQSS) et de la certification des établissements de santé ; évaluer les médicaments, dispositifs médicaux et actes professionnels en vue de leur remboursement. En 2025, la HAS poursuit son engagement dans le champ de la santé mentale et de la psychiatrie en adoptant un programme de travail pour la période 2025-2030 et en faisant de ce champ un axe prioritaire de son projet stratégique.

The Imaginary Healthy Patient

SEYDOU BA, A., GALLIC, E., MICHEL, P., *et al.*

2024

Revue d'économie politique Vol. 134(6): 805-858.

Anxiety and depression may have serious disabling consequences for health, social, and occupational outcomes for people who are unaware of their actual health status and/or whose mental health symptoms remain undiagnosed by physicians. This article provides a big picture of unrecognised anxiety and depressive troubles revealed by a low score on the Mental Health Inventory-5 (MHI-5) with the help of machine learning methods using the 2012 French National Representative Health and Social Protection Survey (Enquete Sante et Protection Sociale, ESPS) matched with yearly healthcare consumption data from the French Sickness Fund. Compared to people with no latent symptoms who did not declare any depression over the last 12 months, those with unrecognised anxiety or depression were found to be older, more deprived, more socially disengaged, at a higher probability of adverse working conditions, and with higher healthcare expenditures backed, to some extent, by chronic conditions other than anxiety or mood disorder.

La psychiatrie de liaison : Vers une conception moderne du soin intégré

SICOT, R.

2025

Gestions Hospitalières 2025(644): 175-178.

La prise en charge des troubles psychiques et somatiques a reposé longtemps sur une séparation rigide, freinant une approche globale et cohérente du soin. La psychiatrie de liaison, qui vise à intégrer l'expertise psychiatrique aux services de soins somatiques, constitue une réponse essentielle à cette dichotomie historique. Pourtant, malgré des besoins croissants et une prévalence élevée des comorbidités psychiatriques chez les patients hospitalisés, son développement en France reste limité. L'auteur explore ici les freins historiques, organisationnels et financiers qui entravent l'essor de cette discipline et propose des pistes pour renforcer son ancrage au sein des établissements hospitaliers, au bénéfice des patients et des soignants.

Macroeconomic antecedents of involuntary psychiatric commitments in Denmark

VÄÄNÄNEN, A.

2025

Social Science & Medicine 377: 118133.

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Aims Economic downturns may increase involuntary psychiatric commitments in a population through several mechanisms. This study examines the population-level association between economic downturns and involuntary psychiatric commitments in Denmark, and assesses whether this relation differs across Danes and non-western immigrants. Methods We examined the relation between quarterly aggregated counts of unemployed persons (exposure) and involuntary psychiatric commitments (outcomes) in the (1) overall population, (2) among Danes (excluding non-western immigrants), and (3) among non-western immigrants in Denmark, over 72 quarters, from 2001 to 2018, using Danish register data. We specified our exposure as the quarterly counts of unemployed persons in Denmark (0, 1 quarterly lags). We used time-series analyses to control for autocorrelation, change in underlying population and quarterly volume of voluntary (i.e. non-coercive) psychiatric inpatient admissions. Results Results from time-series analyses indicate 15 additional involuntary psychiatric commitments in the overall Danish population, one quarter after increase in 50,000 additional unemployed persons (p-value <0.05). We also observe 7 additional involuntary commitments among non-western immigrants at exposure lag 1 (p-value <0.05). Our discovered coefficients correspond with a 2.3 % increase in involuntary commitments in the overall population and a 9 % increase among non-western immigrants one quarter following a 1 standard deviation increase in unemployed persons in Denmark. Conclusions Our findings show an increase in involuntary psychiatric commitments following macroeconomic downturns in Denmark.

Health-related quality of life, service utilisation and costs for anxiety disorders in children and young people: A systematic review and meta-analysis

WANNI ARACHCHIGE DONA, S., MCKENNA, K., HO, T. Q. A., *et al.*

2025

Social Science & Medicine 373: 118023.

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Background Anxiety disorders (ADs) are common mental health issues in children and young people (CYP). The literature on its overall economic burden regarding health-related quality of life (HRQoL), service use and costs is limited. This study synthesises the literature on how ADs are associated with these outcomes in CYP (0–24 years) and caregivers. Method A systematic search was undertaken across six databases from January 2013 to the end of December 2024. Grey literature was also searched. Dual-independent screening and quality assessment were conducted. An adapted version of the Effective Public Health Practice Project tool was used for quality assessment. Narrative synthesis and meta-analysis were conducted. Results Of 41,166 studies identified, 24 studies were included. Most were cross-sectional; only four were longitudinal, with 1.5- to 6-year follow-up periods. Studies found poorer HRQoL in CYP with ADs compared to those without ADs or healthy peers. The meta-analysis found a strong effect on the psychological/emotional and social functioning of HRQoL. Comorbid ADs were also associated with poor overall HRQoL, with a particularly very large effect on emotional functioning. Limited studies show that childhood ADs were associated with increased health service use and costs, with mixed findings on caregivers' HRQoL. Conclusion ADs in CYP were associated with lower HRQoL for CYP and their caregivers, and with increased health service use and costs. This review highlights the need for future research to examine the burden on caregivers and the long-term impact on CYP's HRQoL, service use and costs.

Sociologie de la santé

Sociology of Health

Nothing is so impactful as good theory: Evidence for the impact of the social identity approach to health on policy and practice

CRUWYS, T., HASLAM, S. A., STEFFENS, N. K., *et al.*

2025

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This research sought to evaluate the uptake of research on social identity and health among policymakers and practitioners. It also sought to identify the research outputs that have had the greatest impact and to understand the nature of their impact. Policy impact tools in Elsevier's SciVal institutional subscription were utilised in combination with Overton. We extracted all articles within the social identity approach to health topic 1996–2023 as defined by SciVal, along with all citing policy documents as captured by Overton. Summary statistics and trends for this topic along with seven comparable topics were also extracted. More than 1 in 5 articles on the social identity approach to health are cited in policy documents, a proportion that is greater than that reported in other areas of applied psychology; for example, theory of planned behaviour, self-determination theory, and ego-depletion. Policy documents that advocated for community and social interventions to improve population mental health were particularly likely to draw on this research. Overall, the paper makes two general contributions. First we demonstrate the importance of social identity approach to health research for social/community interventions. We found that social identity and health research has had an outsized impact on policy and discuss several features of the theory and literature that may underpin this impact. Second, we provide a novel method for evaluating research impact that could be utilised across disciplines.

Postures communicationnelles des spécialistes en médecine générale dans le dépistage familial du cancer colorectal

DROUET, G., MOREAU, F., PALIERNE, N., *et al.*

2025

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Introduction : Les apparentés au premier degré de patients atteints de cancer colorectal (CCR) ou d'adénome avancé avant l'âge de 65 ans (patients index) présentent un risque accru de CCR, mais les lignes directrices relatives au dépistage familial des apparentés par coloscopie sont peu suivies. Cette étude a pour objectif de décrire, d'un point de vue linguistique et sociologique, l'implication de spécialistes en médecine générale auprès des patients (apparentés à risque élevé de cancer colorectal ou patients index) et leur posture communicationnelle dans le cadre du dépistage familial auprès des différents protagonistes (autres médecins, patients index, apparentés). Méthode : Elle s'appuie sur 29 entretiens semi-directifs avec des spécialistes en médecine générale français de patients index et/ou de leurs apparentés réalisés par téléphone. Le corpus entièrement transcrit des entretiens a fait l'objet d'une analyse linguistique à l'aide d'un outil lexicométrique qui permet de déterminer les objets de discours et d'une analyse sociologique thématique. Résultats : Les analyses ont montré que le dépistage familial est conditionné par la communication entre les spécialistes en médecine générale et les patients index qu'ils incitent à transmettre les recommandations à leurs apparentés et par les échanges avec les médecins des autres spécialités qui leur envoient des informations précises sur le diagnostic. Les apparentés à risque font l'objet d'une relation plus « classique » avec leur médecin spécialiste en médecine générale qui, par un interrogatoire, recherche les antécédents pour les orienter vers le dépistage approprié. La posture du spécialiste en médecine générale semble donc alterner en fonction de l'interlocuteur (patients index vs apparenté), entre supervision et réflexion, consultation et interrogation, justification et hésitation.

How concepts guide policy: an ethnographic study of the meaning making of "appropriate care" in Dutch healthcare

KRAAIJEVELD, B., WIERINGA, S., ENGEBRETSEN, E., *et al.*

2025

Social Science & Medicine 379: 118152.

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Concepts, such as value-based healthcare, patient-centered care and integrated care, are used to guide and govern healthcare structures and services. Although prior research has pointed us towards the multiplicity of interpretations of these concepts, there is little understanding of how a concept gets attributed a particular meaning from its various understandings. This paper describes how healthcare actors engage in the meaning-making of the concept of appropriate care in a policy process in Dutch healthcare by employing the discourse-analytical lens of Laclau & Mouffe. The policy process was studied from February 2022 to July 2022 by taking on an ethnographic approach, comprising fieldnotes (92 days of observation), drafts of the policy document (N = 77), interviews (N = 4), and documents (N = 88). Data analysis suggested that meaning was attributed to appropriate care through three strategies: hegemonizing (prevailing of discourses), compromising (merging of discourses), and co-existing (discourses put alongside each other). We argue that from the interplay between these three strategies appropriate care and similar concepts attain a meaning which might be able to productively guide and govern care proposing healthcare actors to actively engage with the ambiguity of concepts.

Pourquoi continuer à exercer un travail pénible et déconsidéré ? Le cas des travailleuses d'Ehpad

PLAULT, M. ET XING-BONGIOANNI, J.

2025

Revue de l'Ires(114)

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Les emplois en établissements d'hébergement pour personnes âgées dépendantes (Ehpad) conjuguent de nombreux facteurs défavorables : des conditions de travail pénibles physiquement et psychologiquement, des rémunérations souvent faibles et une image négative. Alors que la majorité des travaux scientifiques sur le sujet étudient les difficultés de recrutement de personnel soignant, cet article propose un autre angle d'analyse en posant la question suivante : pourquoi les travailleuses d'Ehpad acceptent-elle de rester dans le secteur ?

Soins de santé primaire

Primary Healthcare

A new look at physicians' responses to financial incentives: Quality of care, practice characteristics, and motivations

BROSIG-KOCH, J., HENNIG-SCHMIDT, H., KAIRIES-SCHWARZ, N., *et al.*

2024

Journal of Health Economics 94: 102862.

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There is considerable controversy about what causes (in)effectiveness of physician performance pay in improving the quality of care. Using a behavioral experiment with German primary-care physicians, we study the incentive effect of performance pay on service provision and quality of care. To explore whether variations in quality are based on the incentive scheme and the interplay with physicians' real-world profit orientation and patient-regarding motivations, we link administrative data on practice characteristics and survey data on physicians' attitudes with experimental data. We find that, under performance pay, quality increases by about 7pp compared to baseline capitation. While the effect increases with the severity of illness, the bonus level does not significantly affect the quality of care. Data linkage indicates that primary-care physicians in high-profit practices provide a lower quality of care. Physicians' other-regarding motivations and attitudes are significant drivers of high treatment quality.

Impact d'un stage en unité spécialisée en soins palliatifs sur les représentations des étudiants en soins infirmiers. Étude qualitative au sein d'une équipe mobile de soins palliatifs

DEGOIS, M., CHENEVEZ, M., BLANCHOT-GRUET, G., *et al.*

2025

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https://doi.org/10.3917/spub.252.0115

Contexte : Près d'un tiers des étudiants en soins infirmiers (ESI), futurs acteurs clés de l'accès aux soins palliatifs (SP), reconnaissent des attitudes d'évitement à l'égard des patients en fin de vie (FDV). Afin de modifier les représentations qui induisent ces attitudes, dans le cadre du plan national de développement des SP, les ministères de la Santé et de l'Enseignement supérieur instauraient dès 2017 un stage obligatoire en unités spécialisées en SP pour les étudiants en santé. Dès lors, tous les ESI de 3^{e} année de notre ville (20 000 hab.) ont été accueillis en équipe mobile de SP (EMSP) pour un stage de cinq jours. Objectif : Identifier si ce stage modifiait les représentations des SP chez les ESI que nous accueillions et, le cas échéant, en quoi. Méthode : Il s'agit d'une étude qualitative en deux temps. Elle repose sur l'analyse thématique des verbatim recueillis auprès des ESI, durant l'année universitaire 2021-2022, au premier (J1) et dernier jour (J5) de leur stage. Résultats : 31 ESI constituaient l'échantillon. À J1, SP et FDV étaient considérés comme spirituels et pouvaient provoquer des émotions négatives. À J5, les ESI utilisaient le vocabulaire professionnel des SP, portaient un regard neuf sur l'interdisciplinarité, identifiaient mieux les patients nécessitant des SP et les questions éthiques de la FDV. Conclusions : Ce dispositif pédagogique apporte un bénéfice immédiat sur la professionnalisation des représentations des ESI. Même si d'autres travaux sont nécessaires pour en identifier les effets à long terme, nos résultats plaident pour une politique proactive de formation des ESI aux SP.

Healthcare Quality by Specialists Under a Mixed Compensation System: An Empirical Analysis

ECHEVIN, D., FORTIN, B. ET HOUNDETOUNGAN, A.

2025

Health Economics 34(5): 972-991.

https://doi.org/10.1002/hec.4943

ABSTRACT We analyze the effects of a mixed compensation (MC) scheme for specialists on the quality of their healthcare services. We exploit a reform implemented in Quebec (Canada) in 1999. The government introduced a payment mechanism combining a per diem with a reduced fee per clinical service. Using a large patient/physician panel dataset, we estimate a multi-state multi-spell hazard model analogous to a difference-in-differences approach. We compute quality indicators from our model. Our results suggest that the reform reduced the quality of MC specialist services measured by the risk of rehospitalization and mortality after discharge.

Integrated health systems and medical care quality during the COVID-19 pandemic

GHOSH, K., BEAULIEU, N. D., DALTON, M., *et al.*

2025

Health Services Research 60(3): e14433.

https://doi.org/10.1111/1475-6773.14433

Abstract Objective To examine differences between patients treated in integrated systems of care and patients treated outside of such systems during the COVID pandemic in the use of primary and preventive care, emergency services, inpatient services, and mortality. Data Sources and Study Setting Data are used from all enrollees in traditional Medicare aged 66 and older. Study Design Difference-in-differences estimates are calculated from the pre-COVID time period (January 2019–February 2020) to the initial COVID time period (March–May 2020) and the ongoing COVID time period (June 2020–December 2021) for patients treated by primary care physicians working in a health system versus not, and by the type of health system. Data Collection/Extraction Methods Medicare claims data are used to measure monthly claims for office and telehealth visits, mammography, colon cancer screening, inpatient/emergency department visits, and death. Patients are assigned to primary care physicians using common algorithms. Physician membership in a health system is determined from a previously generated dataset. Principal Findings Relative to the pre-COVID period, patients treated in health systems fared no better in maintaining primary care access than patients treated outside of such systems (DID estimate on receipt of office care or telehealth visit = –4%; p < 0.001). In the ongoing COVID time period, non-COVID mortality rose by less in health systems (DID estimate = –0.9%; p < 0.001) and health system patients experienced a greater decline in the use of the emergency department (DID estimate = –1.2%; p < 0.001) and emergency/urgent inpatient care for non-COVID conditions less (DID estimate = –0.7%; p < 0.001). Conclusion Health systems were associated with reduced occurrence of death and adverse medical events, although the effect magnitudes are modest. This reduction appears unrelated to the use of primary care and should be considered in the context of our evolving understanding of the advantages and disadvantages of health systems.

Physician Training In Rural And Health Center Settings More Than Doubled, 2008–24

HAWES, E. M., LOMBARDI, B., ADHIKARI, M., *et al.*

2025

Health Affairs 44(5): 572-579.

https://doi.org/10.1377/hlthaff.2024.01297

Although the federal government has invested in efforts to bolster graduate medical education in rural and underserved areas, no studies have examined whether these programs have succeeded at increasing physician training in these communities. This study measured trends in the number of medical residency training sites in rural and federally qualified health center (FQHC) settings, using data from the Accreditation Council for Graduate Medical Education. The number of residency programs with training in rural sites increased from 120 (6.18 percent of all programs) in 2008–09 to 412 (14.34 percent) in 2023–24, whereas residencies at FQHC sites grew from 69 (3.55 percent) to 321 (11.17 percent). A large proportion of this expansion has been funded through federal investments: 21.6 percent of rural residencies are Rural Residency Planning and Development programs, and 28 percent of all current FQHC-based residencies are Teaching Health Center programs. National initiatives that create more training in rural and health center sites have the potential to increase access to care for underserved populations.

The incentive to treat: Physician agency and the expansion of the 340B drug pricing program

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2025

Journal of Health Economics 101: 102971.

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The 340B Drug Pricing Program incentivizes healthcare providers to increase medication use. It does this by allowing certain safety-net hospitals and clinics to purchase outpatient drugs at considerable discounts from manufacturers but be reimbursed at full price by payers. Yet, previous literature has left largely unstudied how the 340B program influences physician prescribing behavior. In this paper, I provide evidence of physician agency among 340B providers in the treatment of breast cancer. I leverage the staggered diffusion of the program to identify the impact of 340B participation on prescribing behavior and patient outcomes. Physicians who join the 340B program increase the share of patients who receive pharmaceutical treatments and increase the intensity of per-patient prescribing. I also find significant increases in prescribing medications that are not included in clinical treatment recommendations and medications to treat side effects. Despite more intensive treatment use, I find no statistically significant change in survival.

Availability of primary care and avoidable attendance at English emergency departments: A regression analysis

JAMIESON, T., GRAVELLE, H. ET SANTOS, R.

2025

Health Policy 157: 105330.

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Attendances at emergency departments (EDs) by patients who could have been treated in primary care increase waiting times and costs in EDs and may reduce quality of care. This study examines whether the probability that a patient's ED attendance is avoidable is associated with their characteristics and the quality, staffing, and availability of their general practice, particularly its extended hours provision. We estimate ED attendance level linear probability and logistic regressions using data on 10.16M attendances at 144 major EDs by patients aged 16 or over from 6,668 English practices. We use two definitions of avoidable ED attendance: the NHS definition (non-urgent) and a new wider definition (clinically inappropriate). 9.3% of attendances were avoidable according to the NHS definition and 21.8% with our definition. The probability of avoidable attendance was lower for older, female patients, those living in more socioeconomically deprived or sparsely populated areas, or those closer to their practice than to the ED attended. Attendances from practices where a higher proportion of patients get same-day GP appointments, or were aware of early morning extended hours, were less likely to be avoidable. The probability that an ED attendance was clinically inappropriate was about 0.5% smaller during weekends or evenings when the practice had extended hours but was not associated with the overall provision of extended hours by the practice.

Les professionnels de santé assurant le suivi gynécologique en France : différents profils d'activité

KARNYCHEFF, T., CHEVILLARD, G., VOILLEQUIN, S., *et al.*

2025

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Introduction : En France le suivi gynécologique est assuré par trois types de professionnels de santé : les gynécologues, les médecins généralistes et les sages-femmes. L'objectif de cette étude est de décrire au niveau national l'activité de suivi gynécologique de ces différents professionnels de santé libéraux. Méthode : Étude descriptive et analytique d'actes marqueurs d'une activité de suivi gynécologique (prélèvement cervico-vaginal, actes techniques de contraception et première consultation de contraception et prévention) des gynécologues, médecins généralistes et sages-femmes ayant une activité libérale en 2022 à partir des données du Système National des Données de Santé (SNDS) afin d'établir des profils de professionnels de santé par des méthodes d'analyses multivariées (analyse en composante principale et classification ascendante). Résultats : Trois profils de gynécologues, cinq profils de médecins généralistes et quatre profils de sages-femmes se distinguent par l'intensité de leur activité de suivi gynécologique et leur spécialisation sur certains types d'actes. Les professionnels avec une activité de suivi gynécologique importante ont souvent une activité libérale particulièrement intensive, sont plus souvent des femmes et appartiennent aux tranches d'âge les plus jeunes. La répartition territoriale des professionnels avec une activité de suivi gynécologique importante est différenciée selon les professions. Conclusion : Nous montrons une importante hétérogénéité concernant le suivi gynécologique, aussi bien entre les différents types de professionnels qu'au sein d'une même profession. Comprendre l'offre en matière de suivi gynécologique et ses dynamiques implique donc de prendre en compte la variété des acteurs au niveau inter et intra-professionnel.

The Effect of Enrolment Policies on Patient Affiliation to a Family Physician: a quasi-experimental evaluation in Canada

KING, C., LAVERGNE, M. R., MCGRAIL, K., *et al.*

2025

Health Policy 156: 105313.

https://doi.org/10.1016/j.healthpol.2025.105313

Affiliation, defined as having a usual source of care, revealed by patterns of repeated interactions between the patient and a clinician over time, can influence patients' care experience, continuity of care and health outcomes. Many jurisdictions implement primary care enrolment policies, with the motivation to increase affiliation and thereby improve downstream patient outcomes. However, there is little evidence on the impacts of these policies on patient-physician affiliation. Using health administrative data, we evaluated the population-level effects of two policies that encourage primary care enrolment on affiliation in Quebec, Canada. We used quasi-experimental study designs (difference-in-difference and interrupted-time-series) to estimate changes in affiliation that could be attributed to the introduction of these policies. The 2003 policy targeted the enrolment of elderly and/or chronically ill patients, whereas the 2009 policy targeted the general population. We used three measures of patient-physician affiliation: dichotomous and continuous usual provider continuity, and the Reporting a Regular Medical Doctor (RRMD) index. Our analyses for both policies did not yield substantively important changes in our outcomes at the population level. Our effect estimates for both policies were stable under several robustness checks specific to each method. Our results suggest that policies that encourage enrolment do not, on their own, have an impact on patient-physician affiliation. If enrolment policies are not sufficient to increase patient-physician affiliation, further research is needed to understand the factors that influence both affiliation and other downstream outcomes.

Do Physicians Respond to Additional Capitation Payments in Mixed Remuneration Schemes?

KONGSTAD, L. P., DAMSLUND, N., SONDERGAARD, J., *et al.*

2025

Health Economics 34(6): 1143-1159.

https://doi.org/10.1002/hec.4954

ABSTRACT Mixed remuneration schemes with capitation and fee-for-service (FFS) payments hold financial incentives to add patients to the list and provide services to listed patients. However, as patients with complex needs tend to require longer consultations there is a risk of inequality in access if fees are not adjusted to patient characteristics. In this paper, we assess a natural experiment introducing additional capitation for GPs with a high share of complex patients (moderate scheme) and for GPs in certain geographical areas (intensive scheme). GPs are eligible if the complexity of their listed patients exceeds a threshold, but as the scheme is subject to a national budget constraint, some eligible general practitioners (GPs) are left without additional payment. For the most favored GPs, the reform distributed additional capitation at 8% of the total baseline income. We study the effects on the number of patients per GP and the number of services per patient, applying difference-in-difference (DiD) models. For both schemes (moderate and intensive), we find tendencies of reductions in the number of patients served and the level of service provision per patient. This also holds for complex patients indicating that the reform did not improve equity in access. The effect on income showed a 2.5% increase in the first follow-up year but the effect became insignificant in the second year after the reform. We interpret this result as a sign that GPs trade income increases with leisure as suggested by the target income hypothesis.

A Scoping Review of Multilevel Patient-Sharing Network Measures in Health Services Research

KORSBERG, A., CORNELIUS, S. L., AWA, F., *et al.*

2025

Medical Care Research and Review 82(3): 10775587241304140.

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Social network analysis is the study of the structure of relationships between social entities. Access to health care administrative datasets has facilitated use of «patient-sharing networks» to infer relationships between health care providers based on the extent to which they have encounters with common patients. The structure and nature of patient-sharing relationships can reflect observed or latent aspects of health care delivery systems, such as collaboration and influence. We conducted a scoping review of peer-reviewed studies that derived patient-sharing network measure(s) in the analyses. There were 134 papers included in the full-text review. We identified and created a centralized resource of 118 measures and uncovered three major themes captured by them: Influential and Key Players, Care Coordination and Teamwork, and Network Structure and Access to Care. Researchers may use this review to inform their use of patient-sharing network measures and to guide the development of novel measures.

Overlapping markets and quality competition among community health centers

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2025

Health Services Research 60(3): e14396.

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Abstract Objective To examine the response of community health center (CHC) quality to quality levels at neighboring CHCs in the presence of non-price competition. Data Setting and Design A quasi-experimental study of US community health centers. Outcome variables were indices that measured overall quality of CHC care. Using patient flow data, we constructed CHC-specific Hirschman–Herfindahl index (HHI) and competitors' composite quality measure. The plausibly exogenous change in characteristics of "competitors' competitors" was exploited to identify the relationship between competition and quality of care, using a generalized two-stage least square model with instrumental variables. Data Sources and Analytic Sample Using the Health Center Program Uniform Data System (2014–2018), linked with American Community Survey and Medical Expenditure Panel Survey, we analyzed 1098 unique federally funded CHCs in 50 states and District of Columbia which had at least one neighboring CHC and had non-missing data for 2015–2018 (4226 CHC-years). Principal Findings Most of CHCs served populations in overlapping geographic markets, with median market concentration decreasing during the study period. A one-percent increase in competitors' quality was associated with a 0.71-percent increase in an index CHC's composite quality ($p < 0.01$), consisting of a 0.59-percent increase in chronic condition control rates ($p < 0.01$); a 0.68-percent increase in the screening and assessment rates ($p < 0.01$); and a 0.78-percent increase in medication management rates ($p < 0.01$). The association was stronger at CHCs serving a smaller proportion of uninsured patients. No significant quality reaction was observed at CHCs with a percentage of uninsured patients larger than the 75th percentile. We observed no significant associations between HHI and quality. Conclusions Increasing competition does not harm quality of care at CHCs. A CHC appears to improve its quality if its competitors improved quality. The beneficial quality effect was less pronounced in CHCs providing a significant proportion of care to uninsured patients, suggesting lack of incentives faced by these CHCs.

Horizontal equity in primary care financing: an assessment of payments to general practices in England, 2014-2022

LO, C., ANSELMI, L. ET SUTTON, M.

2025

Social Science & Medicine 373: 117996.

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Objectives Previous studies of equity in primary care financing have only considered deprivation as the benchmark for need and focused on specific funding streams. We assessed inequity in payments to primary care providers in England, considering alternative definitions of need and comparing different schemes and changes over time. Methods We used data on annual payments to 7,765 general practices between 2014 and 2022, linked to patient characteristics. We measured need as: (i) demand for care, based on patient appointment attempts; (ii) expected utilisation based on a primary care needs index; (iii) diagnosed morbidity, based on prevalence of 20 chronic conditions; and (iv) expected care burden from diagnosed morbidity, based on a hospital care needs index. We ranked practices by average patient neighbourhood income in 2019, and calculated concentration indices of need and need-standardized payments. We then decomposed the concentration index into need, socioeconomic (income, education, ethnicity, economic activity, rurality), and supply-side factors (practice region, dispensing status, contract type). Results Need was concentrated among poorer populations for most measures: expected utilisation (concentration index (CI) = -0.0169), demand for care (CI = -0.0102) and expected burden from diagnosed morbidity (CI = -0.0097). The concentration of diagnosed morbidity varied across conditions. Total payments were consistently pro-rich, with the highest inequity when defining need by expected utilisation (horizontal inequity index (HI) = 0.0224), followed by diagnosed morbidity (HI = 0.0039). Inequity varied substantially across payment schemes, from pro-rich (HI =

0.03993) for the Minimum Practice Income Guarantee to pro-poor (HI = -0.0938) for the Personal Medical Services expenditure. Socioeconomic and supply-side factors contributed to pro-rich inequalities in payments in all years. Discussion Payments to NHS primary care providers do not fully reflect healthcare need. Clear objectives for resource distribution should be defined and harmonized across different schemes to reduce horizontal inequities.

▶ Démographie et activité de la population des médecins généralistes remplaçants en France en 2022

LORENZO-KAS, C. D. ET VERGÈS, Y.

2025

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Introduction : Selon le CNOM, la part des médecins installés parmi les médecins en activité ne cesse de diminuer depuis 2010, alors que celle des remplaçants augmente car cette activité serait de plus en plus plébiscitée par les jeunes médecins. Cette étude avait pour objectif de décrire la population des médecins généralistes remplaçants en France métropolitaine en 2022 et de caractériser leur activité professionnelle. Méthodes : Étude observationnelle quantitative rétrospective par le biais d'un auto-questionnaire déclaratif en ligne, diffusé par mail et via les réseaux sociaux. Résultats : 624 réponses ont été collectées, et 612 ont été retenues pour l'étude. 72 % des médecins généralistes remplaçants de notre échantillon étaient des femmes, l'âge moyen était de 33 ans et 75 % avaient déjà soutenu leur thèse. 77 % exerçaient leur activité en libéral exclusivement, 79 % dans des cabinets médicaux en association. 73 % effectuaient au moins un remplacement régulier. Les participants remplaçaient en moyenne 7 médecins par an, travaillaient près de 32 semaines par an et 7 demi-journées par semaine. Près de la moitié (45 %) travaillaient 8 demi-journées par semaine ou plus. 44 % participaient à la permanence des soins ambulatoires. L'état de santé global des répondants était plutôt bon avec un ressenti à 7,6/10 en moyenne, mais leur santé psychique était plus précaire. Enfin 59 % des médecins interrogés exprimaient un désir d'installation. Conclusion : Les données de représentativité des médecins généralistes remplaçants sont rares ; dans notre étude, ils rapportent une activité significative qui peut les identifier comme un maillon essentiel de la continuité des soins, et un atout pour les médecins installés contrairement aux idées reçues. Il serait intéressant d'étudier les revendications des jeunes médecins généralistes concernant leur exercice futur et leur vie professionnelle, au sein d'un système de soins en pleine mutation.

▶ Recruitment and Retention of Rural Health Professionals in Minnesota

MACDOUGALL, H., WOLDEGERIMA, S., HENNING-SMITH, C., *et al.*

2025

Health Services Research 60(3): e14453.

https://doi.org/10.1111/1475-6773.14453

ABSTRACT Objective To qualitatively explore the reasons health professionals decide to practice in rural areas. Study Setting and Design Exploratory, cross-sectional, semi-structured qualitative interview and focus group study using thematic analysis with a convenience sample of health professionals in rural Minnesota. Interviews and focus groups were conducted virtually and in person, respectively, between August 2023 and March 2024. Data Sources and Analytic Sample Primary interview and focus group data were collected from 19 individual interviews and 3 focus groups (n = 16) with health professionals in rural Minnesota. Interview and focus group recordings were transcribed, deductively coded, and analyzed using constant comparison. Principal Findings Rural health professionals cited autonomy and breadth of practice and patient connection as rewarding and challenging components of practice that were distinctly rural. Barriers to recruitment and retention of rural health professionals included lack of housing (especially rental and short-term) and accessible childcare. Potentially promising considerations when recruiting and retaining health professionals include loan forgiveness programs, the appeal of increasing racial and ethnic diversity in rural areas, and the ease of community health advocacy efforts. Conclusion Our findings suggest that to recruit and retain rural health professionals, stakeholders could highlight autonomy and patient connection, reduce childcare and housing barriers, and explore community strengths such as racial/ethnic diversity and opportunities for advocacy.

Overseas General Practitioners (GPs) and Opioid Prescriptions in England

MADIA, J. E., NICODEMO, C., ORSO, C. E., *et al.*

2025

Health Policy 159: 105362.

https://doi.org/10.1016/j.healthpol.2025.105362

The substantial recent rise in opioid prescription rates, along with increasing evidence of misuse and associated morbidity and mortality, raises serious concerns about the appropriateness of these drugs for pain management. This study investigates prescription behaviour differences across opioid drug categories between UK-trained and overseas-trained GPs. Using panel data covering all English practices from 2018 to 2021, we find a strong association between practices with more overseas GPs and opioid prescription patterns. Regional differences emerge, with GPs from North America prescribing more opioids and those from Africa and Asia prescribing less, relative to the UK-trained counterparts. Heterogeneous cultural norms, different training environments, and varying epidemiological patterns might explain these different prescribing behaviours. Comprehensive cross-country assessments of GP competencies could identify areas for targeted training, helping to align the practices of foreign-trained GPs with UK standards while supporting the attraction of global talent.

Increasing expenditures on home- and community-based services: Do home care workers benefit?

MILLER, K. E. M., COE, N. B., KREIDER, A. R., *et al.*

2025

Health Services Research 60 (Suppl 2): e14399.

https://doi.org/10.1111/1475-6773.14399

Abstract Objective To examine the association of Medicaid home- and community-based services (HCBS) expenditures on the home care workforce. Data Sources/Study Setting We use two national, secondary data sources from 2008 to 2019: state-level Medicaid HCBS expenditures and the American Community Survey, in which we identify direct care workers in the home (i.e., home care workers), defined as nursing, psychiatric, and home health aides or personal care aides working in home health care services, individual and family services, and private households. Study Design Our key explanatory variable is HCBS expenditures per state per year. To estimate the association between changes in Medicaid HCBS expenditures and the workforce size, hourly wages and hours worked, we use negative binomial, linear, and generalized ordered logit regression, respectively. All models include demographic and socioeconomic characteristics, the number of potential HCBS beneficiaries (individuals with a disability and income under the federal maximum income eligibility limits), indicators for minimum wage and/or overtime protections for direct care workers, wage pass-through policies, and state and year fixed effects. Data Collection/Extraction Methods We exclude states with incomplete reporting of expenditures. Principal Findings States' HCBS expenditures increased between 2008 and 2019 after adjusting for inflation and the number of potential HCBS beneficiaries. Yet, home care workers' wages remained stagnant at $11–12/h. We find no association between changes in Medicaid HCBS expenditures and wages. For every additional $1 million in Medicaid HCBS expenditures, the expected number of workers increases by 1.2 and the probability of working overtime increased (0.0015% points; $p < 0.05$). Results are largely robust under multiple sensitivity analyses. Conclusions We find no evidence of a statistically significant relationship between changes in state-level changes in Medicaid HCBS expenditures and worker wages but do find a significant, but small, association with hours worked and workforce size.

The Effects of Resigning GPs on Patient Healthcare Utilization and Some Implications for Health

MONSEES, D. ET WESTPHAL, M.

2025

Health Econ 34(5): 932-955.

https://doi.org/10.1002/hec.4941

We study the effects of general practitioners' (GPs') resignations on their patients' healthcare utilization and diagnoses in an event-study setting. Using claims data from a large German statutory health insurance, we find that after physicians leave, their former patients persistently reduce their primary care utilization, only partially substituting it with specialist visits and hospital care. Because patients find a new GP already 1.1 quarters after the old resigns, on average, the persistent effects must be explained through the new GP. Indeed, the new GP serves more patients but performs less diagnostic testing. Our results reveal a substantial decrease in diagnoses of many relevant chronic conditions (such as congestive heart failure and diabetes), suggesting that disruptions may have adverse consequences for the efficiency of the healthcare system.

This indicates that continuity in primary care is pivotal and shows that the GP has an essential role in healthcare delivery, particularly in healthcare systems such as Germany, where GPs often have a high workload and little consultation time.

Pathways To Primary Care: Charting Trajectories From Medical School Graduation Through Specialty Training

PHILLIPS, W. R., PARK, J. ET TOPMILLER, M.

2025

Health Affairs 44(5): 580-588.

https://doi.org/10.1377/hlthaff.2024.00893

Shortages of primary care physicians threaten access, quality, and equity in US health care. Policy solutions face disinformation about the complex patterns of physician training. This retrospective cohort study used American Medical Association Physician Masterfile and Historical Residency File data to identify physicians' trajectories from medical school graduation through postgraduate training into primary care specialties for doctors of medicine, doctors of osteopathic medicine, and international medical graduates. Sankey diagrams illustrate flows through training programs. Among 353,590 physicians who graduated during the period 2001–15, 11.8 percent pursued initial training in family medicine, 33.5 percent training in internal medicine, and 10.5 percent training in pediatrics. Primary care yield, defined as the percentage of physicians who complete their initial postgraduate training in a primary care specialty and conclude their training in any primary care specialty, was 97.0 percent for family medicine, 35.5 percent for internal medicine, and 54.4 percent for pediatrics. After internal medicine and pediatrics residencies, large percentages of physicians left primary care to train in subspecialties and other fields. Further research must document how many physicians enter careers in primary care practice.

When women take over: Physician gender and health care provision

PRUCKNER, G. J., STIFTINGER, F. ET ZOCHER, K.

2025

Journal of Health Economics 102: 103000.

https://doi.org/10.1016/j.jhealeco.2025.103000

The share of female physicians has risen in OECD countries in recent decades, but we know little about the effects of physician gender on patient health care use. We exploit quasi-random assignment of primary care providers (PCPs) to existing PCP practices and patients and estimate the causal effect of female PCPs on health care provision. Using Austrian register data and a difference-in-differences strategy, we find that female PCPs generate 15% less revenue and see 7% fewer patients than male PCPs. Shifting the focus to patient-level outcomes, we observe that health care utilization remains largely unchanged following assignment to a female physician. However, results show that patients are more likely to leave PCP practices with female successors. Our results do not support the idea that the decision to change PCP is driven by preferences against being treated by female physicians. Instead, our analysis suggests that the observed differences are partly explained by female PCPs working fewer hours, especially those facing working time restrictions. As the share of female physicians continues to rise, measures to increase work flexibility may be necessary to maintain broad access to outpatient health care.

Contact time in GP Care: Descriptive patterns and a scoping review of the literature

REIF, S., KOHLER, J., SCHUBERT, S., *et al.*

2025

Health Policy 156: 105315.

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Background Contact time in general practice (GP) refers to the duration a physician spends with a patient during an appointment. There are significant differences in contact times across OECD countries, raising questions about the influencing factors and potential consequences of these variations. Objective To study the determinants and consequences of the length of consultations in GP care. Method We descriptively investigate differences in average appointment durations in GP care across OECD countries. We then conduct a scoping review of the literature encompassing 150 studies in seven topical clusters. Results We identify considerable differences in contact times across countries and find evidence for substitution effects between the length of consultations and the number of consultations per year. There is also an association between reimbursement schemes and visit lengths. The review reveals consistent evidence for a few determinants, such as patient characteristics and physician experience, but mixed evidence on the effects of contact time on shared decision-making and health outcomes. The literature is dominated by correlational studies. Conclusion Descriptive comparisons show shorter contact times are substituted with more frequent visits, and fee-for-service payment systems result in longer contact times compared to capitation systems. For future health policy discussions, it is crucial to clarify which service delivery form is socially desired and economically sustainable.

▶ Sustainability of California's Whole Person Care pilots integrating medical and social services for Medicaid enrollees via newly developed Medicaid benefits

SAFAEINILI, N., CHUANG, E., FLEMING, M., *et al.*

2024

Health Serv Res 60 (Suppl 3): e14418.

https://doi.org/10.1111/1475-6773.14418

OBJECTIVE: To assess multi-level factors influencing the sustainability of 26 social care pilots integrating medical and social services for Medicaid enrollees across California in newly developed Medicaid benefits. STUDY SETTING AND DESIGN: This qualitative study assessed the sustainability of Whole Person Care (WPC) pilots implemented between 2016 and 2021. Pilots (n = 26) represented a majority of counties in California. DATA SOURCES AND ANALYTIC SAMPLE: Primary qualitative data were collected between June and August 2021 and included 58 hour-long, semi-structured individual and group interviews with administrators, middle managers, and frontline case management staff representing all WPC pilots. We used hybrid inductive-deductive thematic analysis to identify and analyze patterns, and outliers, in factors influencing sustainment. Deductive codes included established implementation science factors influencing the sustainability of new programs (e.g., innovation characteristics, capacity, processes and interactions, and context). PRINCIPAL FINDINGS: Of 26 WPC pilots, 22 pilots sustained WPC by contracting with Medicaid managed care plans to provide services as part of newly developed Medicaid benefits. Three pilots chose not to sustain before the pilot period ended and one pilot decided not to sustain following completion of the full pilot. Factors influencing sustainability included: (1) program adaptability and flexibility; (2) funding structure and reimbursement requirements; (3) shared leadership with managed care plans; and (4) whether pilots chose to build out program infrastructure internally or contracted out core components to partner organizations. Many pilots, particularly those in rural areas, indicated that system and policy changes introduced as part of transitioning pilot services into Medicaid benefits reduced the sustainability of WPC for participating providers. CONCLUSIONS: Multi-level factors including program adaptability, funding, leadership, and capacity to build out infrastructure influenced the sustainability of WPC pilots. These findings have significant implications for health equity as equitable distribution of services, resources, and benefits from these programs can be supported through sustained implementation over time.

▶ Updated Medicaid-To-Medicare Fee Index: Medicaid Physician Fees Still Lag Behind Medicare Physician Fees

SKOPEC, L., PUGAZHENDHI, A. ET ZUCKERMAN, S.

2025

Health Affairs 44(5): 531-538.

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Medicaid plays a critical role in the US health insurance system, but a history of low physician fees has limited physicians' participation in the program. Recent Centers for Medicare and Medicaid Services rules have sought to encourage states to increase their Medicaid physician fees to at least 80 percent of Medicare fees, based on the methods used in the Urban Institute's periodic surveys of Medicaid physician fees. In this article, we show that between 2019 and 2024, Medicaid fees increased slightly, from 72 percent of Medicare fees to 75 percent of Medicare fees for a basket of twenty-seven common physician services. In addition, because the current Medicaid population includes far more nonelderly, nondisabled adults than when the original basket of services was chosen, we present an updated index that better reflects current patterns of spending and service use. We found that, based on this updated index, Medicaid physician fees were approximately 71 percent of Medicare physician fees in 2024, including 69 percent for office visits, 68 percent for hospital and emergency department visits, 87 percent for obstetric care, and 79 percent for other services under our updated approach.

▶ Better Together? A Mediation Analysis of French General Practitioners' Performance in Multi Professional Group Practice

ZAYTSEVA, A., VERGER, P. ET VENTELOU, B.

2025

Health Services Insights 18: 11786329251331128.

https://doi.org/10.1177/11786329251331128

Background: Integrated primary care teams remain a debatable policy in family medicine that could be a convenient response to French shortages in medical density. Objectives: To analyse how general practitioners (GPs) respond to insufficient GP supply in their practice area in terms of quantity and quality of care, and how this response is mediated by enrolment in integrated primary care teams – multi-professional group practices (MGPs).Methods: We used structural equation modelling on 3 representative cross-sectional surveys (2019-2020) of 1209 French GPs. Quantity and quality of care were approximated by latent variables comprising respectively GPs' demand absorption capacity and frequencies of vaccine recommendations. Results: In the absence of potential mediators, low GP density was negatively associated with quantity (−0.221, unstandardized direct effects), but not with the quality of care. In the presence of mediators, low GP density was associated with higher work-related stress (0.120), which was consecutively associated with deteriorated demand absorption capacity (−0.202). Higher use of e-health tools was associated with greater involvement in vaccine recommendations (0.357). GPs in MGPs tended to use more e-health tools than those practicing outside MGPs (0.032), with a favourable effect on vaccine recommendations. Conclusion: Lower level of work-related stress is the key mediator in handling patients' requests. When correcting for self-selection into MGPs, we found no significant mediation effect of enrolment in MGPs on the quantity of care but rather an effect on the quality of care. Our results pinpoint an added value of an enrolment in an MGPs to care quality that advocates for its further development.JEL Classification: I14, I18

Systèmes de santé

Health Systems

Les compagnies d’assurance santé, au coeur des rancoeurs et frustrations du public vis-à-vis du système de santé

SAUVIAT, C.

2025

Chronique Internationale de l’Ires(189): 65-79.

L’assassinat du P-DG de UnitedHealthcare, la plus grande compagnie d’assurance santé aux États-Unis, a remis le système de santé américain et ses dysfonctionnements au cœur du débat médiatique. L’article revient sur les évolutions récentes de ce système, son coût extrêmement élevé, la domination des compagnies d’assurance de plus en plus concentrées et financiarisées et les pratiques commerciales de ces dernières, comme les refus de remboursement des soins qui ont fait resurgir la colère et les frustrations du public.

Growth and Changing Landscape of the Cost-Utility Literature: An Australian Perspective, 1992-2022

XIA, Q., MCPHAIL, S. M., AFOAKWAH, C., *et al.*

2025

Health Policy 156: 105319.

https://doi.org/10.1016/j.healthpol.2025.105319

Background Since the introduction of cost-utility analysis (CUA) in the 1990s, its methodologies and applications have evolved significantly in Australia. Objectives To provide a comprehensive overview of the volume, trends, and characteristics of the application of CUA in healthcare decision-making. Methods Bibliometric analysis of published CUAs identified from the Cost-Effectiveness Analysis Registry, a comprehensive source of CUA data between 1992-2022. Multinomial logistic regression models were conducted to explore the associations between ICERs and variables including sponsorship, perspective, and discount rate. Results N=484 unique Australian-based CUAs were analysed. Over the last three decades, the volume and quality of CUAs in Australia have steadily increased. Commonly evaluated interventions included pharmaceuticals (21.5%), health education/behaviour (18.0%), and models of care (16.6%), while diseases of circulatory system, cancers, and metabolic diseases were the most studied health conditions. Only nine CUAs involved First Nations people. Most CUAs (72.9%) were conducted from a healthcare payer perspective, with only 19.0% adopting a societal perspective. Approximately half of studies applied a 5% discount rate, and 50.4% used a $50,000 WTP threshold. 14.7% CUAs were sponsored by industry. Regression analyses showed that industry sponsorship, societal perspective, and lower discount rate were positively associated with lower ICERs. Conclusions The increasing volume of CUAs underscores the importance of efficient allocation of scare resources in Australian health system. However, gaps remain, particularly in the inclusion of First Nations populations and the societal costs. Further research is needed to address these gaps and to evaluate the impact of sponsorship and discounting on CUA outcomes.

Travail et santé

Occupational Health

Disability insurance screening and worker health

AHAMMER, A. ET PACKHAM, A.

2025

Journal of Health Economics 101: 102986.

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We provide new evidence on the returns to more targeted disability insurance (DI) programs in terms of labor force participation, program spillovers, and worker health. To do so, we analyze Austrian workers after a workplace injury that experience differential levels of application screening. We find that when workers face stricter screening, they are more likely to remain in the labor force. However, we estimate no statistical differences in any physical or mental health outcomes, and can rule out large effects on overall healthcare utilization. Our findings imply that imposing stricter DI screening can yield large fiscal benefits, on the margin.

Impact du stress professionnel sur la santé physique des travailleurs : une revue systématique utilisant la méthode PRISMA

BATTAL, S. ET TOUFIK, S.

2025

Santé Publique vol. 37(2): 185-202.

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Plusieurs études de la littérature ont affirmé l'incidence substantielle du stress professionnel (SP) sur la santé physique des travailleurs, le définissant comme un problème de santé publique grave à l'échelle internationale. Cette étude vise à réaliser une revue systématique et une analyse de la littérature sur les études qui ont investigué la corrélation positive entre le SP et les troubles physiques chez les travailleurs. L'objectif est de mettre en évidence des données solides pour aider à sensibiliser sur l'urgente nécessité de prévenir les conséquences graves du stress professionnel sur la santé des travailleurs. Ces résultats servent également de point de départ important pour les études futures sur le sujet. La revue de la littérature a été réalisée en utilisant la méthode « Preferred Reporting Items for Systematic Reviews (PRISMA) » comme guide formel pour la collecte systématique des données. Les données ont été obtenues à partir des sources suivantes : SCIENCEDIRECT, PubMed, Medline, CAIRN et Semantic Scholar, en langues française et anglaise. Dix-neuf études publiées entre 2000 et 2023 ont été répertoriées. Les troubles physiques identifiés selon cette revue incluent les maladies cardiovasculaires, le diabète, l'hypertension, les troubles musculosquelettiques, les troubles digestifs, la fatigue et la prise ou perte de poids. Des études de plusieurs pays ont été examinées, mais très peu d'études sur le SP et son impact sur la santé ont été trouvées dans la littérature des pays du Moyen-Orient et d'Afrique. Ce travail analytique a fourni des preuves solides issues de la littérature concernant la forte corrélation positive entre le stress professionnel (SP) et la santé physique des travailleurs. Par conséquent, des stratégies efficaces doivent être mises en œuvre à l'échelle internationale pour préserver la santé et le bien-être des travailleurs.

Évolution des troubles mentaux liés au travail au Québec entre 2012 et 2021

BILODEAU, J., LEBEAU, M., BUSQUE, M. A., *et al.*

2025

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https://doi.org/10.3917/spub.252.0229

Introduction : Plusieurs pays ont connu une augmentation du nombre de troubles mentaux acceptés au cours des dernières années, mais les variations possibles de cette évolution dans la main-d'œuvre demeurent à explorer. But de l'étude : Cette étude examine la distribution dans le temps des troubles mentaux acceptés selon la profession, le secteur industriel, le sexe et l'âge au Québec. Résultats : Les taux d'incidence des troubles mentaux et leur évolution varient selon la profession et le secteur industriel. Alors que le taux est généralement plus élevé dans les professions mixtes et le secteur tertiaire, l'augmentation de ces taux s'observe davantage dans les professions non manuelles et le secteur primaire. Des variations importantes sont également observées par catégorie de sexe et pour certains groupes d'âge. Conclusions : Le recours aux données administratives sur les troubles mentaux acceptés permet d'offrir un portrait complémentaire aux données d'enquêtes quant à la santé mentale au travail selon différents groupes de travailleurs. La croissance des taux de troubles mentaux acceptés pointe vers des groupes à prioriser en matière de prévention de cette catégorie de lésion professionnelle.

Recurrent major depression, employment and transitions to unemployment and disability benefits

CAU, Q., GANDRÉ, C. ET LENGAGNE, P.

2025

Social Science & Medicine 377: 118056.

https://doi.org/10.1016/j.socscimed.2025.118056

This study assesses the effects of recurrent major depression on employment and transitions to unemployment and disability benefits. Examining this issue is essential for designing timely interventions aimed to sustain individuals' employment. We rely on register data of a sample of individuals initially employed—a 2% sample of employees representative of French private-sector employees—followed up to eight years before and eight years after the year of diagnosis, aged between 20 and 60 years, over the period 2000–2015. We estimate that recurrent major depression persistently decreases the likelihood of being employed by

35 percentage points and annual earnings by 51%, and leads to increase the probability of long absence by 47 percentage points and the probability of permanent disability benefit recipiency by 33 percentage points. The effect sizes are similar between men and women. We find differences between age groups. For young and middle-aged individuals, recurrent major depression implies a decrease in employment rates, an increase in unemployment benefit rates and a persistent increase in disability benefit recipiency rates. Many young ill individuals remain attached to the labor market but experience unemployment and a large decline in annual earnings. For older individuals, recurrent major depression leads to a larger decrease in employment rates and a greater increase in disability benefit recipiency rates, compared to younger individuals. We conclude that differentiated policies tailored to age groups might be developed to support the employment of individuals with recurrent major depression.

Precarious employment in self-employment: A typology and impact on cardiovascular health conditions in Sweden

GEVAERT, J., MANGOT-SALA, L., ALMROTH, M., *et al.*

2025

Social Science & Medicine 379: 118182.

https://doi.org/10.1016/j.socscimed.2025.118182

Background Research on health in self-employment shows mixed findings, partly due to limited focus on heterogeneity within self-employment, physical health outcomes and reliance on self-reported, cross-sectional data. This study addresses these gaps by identifying self-employment types using the 'precarious employment framework' and examining their association with cardiovascular health conditions in Sweden. Methods Using the Swedish Work, Illness, and Labour Market Participation (SWIP) cohort, we analyzed individuals born between 1948 and 1968, aged 40–60 in 2008, and living in Sweden in 2005. We identified a typology of precarious self-employment in 2008 (N = 281,251), with cardiovascular health conditions tracked between 2009 and 2020. Latent Class Analysis (LCA) was used to categorize self-employment based on six indicators of precarity: business type, prior unemployment, combined employment, number of employees, income, and income volatility. Cox proportional hazards models estimated the association between the self-employment types and cardiovascular health conditions (diagnoses for myocardial infarction and stroke) compared to waged employment, adjusting for covariates. Results We identified four self-employment types: entrepreneurial employers, precarious solo self-employed, own-account combiners, and small traders. Precarious self-employment among 40-to-60-year-olds was associated with a higher risk of cardiovascular conditions later in life. The 'precarious employment framework' effectively captures the heterogeneity of self-employment and highlights its role as a social determinant of cardiovascular health. Conclusion Our findings suggest that precarious self-employment is linked to increased cardiovascular risk. This underscores the importance of considering employment quality and heterogeneity in future research and public policies addressing self-employed populations.

Evaluate The Health Risks and Impact Pathways of Precarious Employment in the Context of Globalization: A National Longitudinal Research from 2017 to 2023 in Japan

LI, D., YAMADA, M., FENG, W., *et al.*

2025

Social Science & Medicine 374: 118063.

https://doi.org/10.1016/j.socscimed.2025.118063

Background Since the 1970s, neoliberalism has transformed the global economy, replacing full-time, long-term employment with flexible work arrangements, contributing to precarious employment (PE). PE has been linked to negative health outcomes, but research on the multiple dimensions of PE remains limited. Methods This study employed a longitudinal cohort design using data from the Japanese Panel Study of Employment Dynamics (JPSED) from 2017 to 2023, focusing on individuals aged 16–65 who were employed but not on full-time permanent contracts. We developed a modified Employment Precariousness Scale (EPRES-JP) for evaluation. The entropy-based TOPSIS method with adjustable weight coefficients (Ea-TOPSIS) method was applied to calculate the Precarious Employment Index (PEI), and logistic regression analyzed its association with health outcomes, while Structural Equation Modeling (SEM) explored potential mediating pathways. Results The study found that the «Rights» dimension (social insurance and leave access) had the highest average weight at 40.2%, with the impact of COVID-19 (introduced in 2021) significantly contributing to the PEI. Higher PEI was associated with greater risks of headaches (OR0.1=1.11, 95% CI [1.06, 1.16]), fatigue (OR0.1=1.09, 95% CI [1.04, 1.14]), anxiety (OR0.1=1.12, 95% CI [1.07, 1.17]), depression (OR0.1=1.18, 95% CI [1.13,1.24]), loss of appetite (OR0.1=1.22, 95% CI [1.16, 1.28]), and sleep disturbances (OR0.1=1.20, 95% CI [1.15, 1.25]). SEM identified mediating pathways between PE, job and life satisfaction, and health outcomes. Conclusion These findings deepen our understanding of how PE affects worker health. Enhancing job characteristics and life satisfaction may mitigate the health risks of PE. Broader labor policies are essential to improve job security and worker well-being.

▶ Do type, timing and duration of life course non-employment differentially predict dementia risk? An application of sequence analysis

PACCA, L., GAYE, S. A., BRENOWITZ, W. D., *et al.*

2025

Social Science & Medicine 372: 117976.

https://doi.org/10.1016/j.socscimed.2025.117976

Periods out of employment may influence dementia, but characterizing lifecourse employment is difficult and prior research is sparse. This study used sequence and cluster analysis to characterize type, timing, and duration of lifecourse work gaps and estimate associations with dementia risk. Life History Mail Survey supplement to the U.S. Health Retirement Study participants (N=5,945, 13.6% of the Health and Retirement Study sample) reported lifecourse employment (full time or part time) and reasons and age of work gaps (unemployment, schooling, caregiving, or disability). Our exposure was gender-stratified employment trajectories from age 18-65, characterized using sequence analysis and cluster analysis. Our outcomes were algorithmically defined dementia probability scores and memory scores. We estimated the association between employment trajectories and dementia risk using generalized estimating equations and memory decline using linear mixed effect models, adjusted for age, gender, birthplace, and childhood socioeconomic status. We identified 11 employment trajectories for women (including predominant work, disability, unemployment, caregiving, retirement) and 10 for men (similar, but no caregiving). Compared to “predominant work”, “disability” and “unemployment” trajectories were associated with higher dementia risk for men and women (e.g., disability among women: OR=3.62;95%CI=2.25,5.81). Among women who cared for family, those who did not re-enter the labor force full-time had higher dementia risk (e.g. “family gap, go back part time”: OR=1.79;95%CI=1.15,2.79) compared to the predominant work cluster. Women who cared for family and returned to full-time work had similar cognitive outcomes as those in the predominant work cluster. Men who had long spells of part-time work also had elevated dementia risk (e.g. part time earlier: OR=1.64;95%CI=1.16,2.57). Finally, women and men with long periods of unreported employment status had higher dementia risk than those in the predominant work trajectory. Results suggest the type, timing and duration of work gaps are differentially associated with dementia risk. Work gaps due to disability, unemployment or unreported employment status predicted higher dementia risk. Permanently leaving full-time work for caregiving predicted worse cognitive outcomes but temporary caregiving-related interruptions in work did not.

▶ Travail : la santé des femmes à la peine

REVUE PRESCRIRE

2025

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Cette synthèse fait le point sur les problématiques de la santé au travail des femmes : Manque de prise en compte des risques auxquels sont exposées les femmes. Des conditions de travail plus difficiles qu’il n’y paraît; Des risques professionnels sous-estimés; Les femmes exposées aux substances cancérogènes dans les secteurs du nettoyage et du soin; Prise en compte de la santé sexuelle et reproductive des femmes à améliorer; Différencier n’est pas discriminer.

▶ The Impact of Minimum Wages on Overall Health and Well-being: Global Evidence from the Gallup World Pol

SOTIRAKOPOULOS, P., GUVEN, C., ULKER, A., *et al.*

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Social Science & Medicine 375: 118064.

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We examine the impact of minimum wage increases on the overall self-reported health and subjective well-being of low-skilled workers using the Gallup World Poll from 2009 to 2020. We identify effects using within-country changes over time and cross-country variations in the timing and intensity of minimum wage increases across 87 countries. Our findings suggest that minimum wage increases benefit health and certain dimensions of subjective well-being. Specifically, we estimate a range of specifications and find that a 10 percent increase in the minimum wage leads to an increase in self-reported health ranging from 0% to 1% and an increase in satisfaction with the standard of living between 1% and 6%, at the outcome means. Minimum wage increases are linked to higher incomes, a lower likelihood of overtime work, enhanced social interactions, and more positive daily experiences. These benefits are especially significant in countries with stronger rule of law, among male workers, and for individuals in nations with free and universal healthcare access. A series of sensitivity and placebo tests confirm the robustness of these findings.

Economic Shocks and Infant Health: The Intergenerational Effects of Import Competition in the U.S

UKIL, P.

2025

Health Economics 34(6): 1121-1142.

https://doi.org/10.1002/hec.4946

ABSTRACT This paper investigates the intergenerational health impacts of a persistent negative economic shock faced by individuals residing in the United States. Specifically, the paper examines the impact of economic shocks in local labor markets on infant health by exploiting the increasing import competition from China between 2005 and 2015 on U.S. commuting zones as a plausibly exogenous source of variation in household economic conditions. Using yearly restricted-access data from the Natality Vital Statistics and yearly measures of the U.S local labor markets' exposure to import competition at the per capita level, this paper provides evidence that negative shocks in the form of worsening local labor market conditions are associated with a negative impact on infant health outcomes. Results indicate that increased import penetration from China in U.S commuting zones led to a reduction in the average birthweight and an increase in the incidence of low birthweight. Analyses of transmission mechanisms suggest worsening household economic circumstances as a result of negative labor market outcomes in the form of reduced wages, reduced household income per capita and increased reliance on food stamps, reduced access to healthcare and an increase in mental health declines among women of childbearing age.

Vieillissement

Ageing

There Is No Place Like Home: The Impact of Public Home-Based Care on the Mental Health and Well-Being of Older People

CARRINO, L., REINHARD, E. ET AVENDANO, M.

2025

Health Economics 34(6): 1085-1102.

https://doi.org/10.1002/hec.4948

ABSTRACT Despite a significant policy shift from institutional to home-based care for older adults, evidence on the effectiveness of policies incentivizing home care is limited. This study provides novel evidence on the causal effect of public home-based care on the mental health and well-being of older people. To address endogenous selection, we implement a novel instrumental variable approach that exploits eligibility rules for long-term care as defined in national legislations. We link longitudinal data from the Survey of Health, Aging & Retirement in Europe (SHARE, 2004–2017) to national LTC eligibility rules in France, Germany, Spain and Belgium (disaggregated for Wallonia and Flanders regions) and examine how exogenous variation in the use of long-term care caused by varying eligibility rules impacts depressive symptoms (EURO-D scale), quality of life (CASP scale) and loneliness (R-UCLA scale). We find that receiving formal home-based care significantly reduces depressive symptom scores by 2.6 points (large effect size measured by Cohen's d) and the risk of depression by 13 percentage points. The use of home-based formal care also increases quality of life as measured by the CASP scale, particularly by increasing feelings of control over life. We show that one potential mechanism involves the impact of home-based care on loneliness: we estimate that receiving formal home-based care reduces the risk of loneliness by 6.7 percentage points. Our results provide evidence that an increase in home-based care coverage is justified in terms of improved mental health and well-being outcomes for older people.

Long-Term Care Partnership Effects on Medicaid and Private Insurance

COSTA-FONT, J. ET RAUT, N.

2025

Health Economics 34(6): 1171-1187.

https://doi.org/10.1002/hec.4949

ABSTRACT We examine the impact of the Long-Term Care Insurance Partnership (LTCIP) program—a collaborative initiative between the state-level Medicaid programs and private health insurance companies designed to promote private long-term care insurance (LTCI)—on insurance ownership and Medicaid utilization. We draw on individual-level longitudinal data and employ a difference-in-differences (DD) design adjusted for the staggered implementation of the program between 2005 and 2018. Our results suggest that the rollout of the LTCIP program led to a 1.54 percentage point (pp) (14.7%) increase in LTCI ownership and a 0.82 pp (13.3%) reduction in Medicaid uptake. Our estimates suggest that these combined effects led to an approximate average cost saving of $74 per 65-year-old participant. These findings are explained by a certain degree of substitution between LTCIP and traditional LTCI contracts, ultimately postponing the use of Medicaid benefits.

Deteriorating care home residents as 'matter out of place' in both care homes and hospitals: An ethnographic study

HARRAD-HYDE, F., WILLIAMS, C. ET ARMSTRONG, N.

2025

Social Science & Medicine 373: 118012.

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Abstract: Older people living in care homes are susceptible to deteriorations in their health. At times of deterioration, care home staff play a crucial role in considering the potential benefits and burdens associated with either caring for the resident in the home or transferring them to hospital. Using data collected through interviews with 30 care home staff and 113 hours of ethnographic fieldwork in care homes in England, we consider the ways that care home staff can perceive deteriorating care home residents to be, often simultaneously, vulnerable (or 'at risk') and dangerous (or 'a risk') in both the hospital and the care home. Drawing on the work of Mary Douglas, we suggest deteriorating care home residents can be considered to be 'matter out of place' and can therefore be considered as 'placeless' in whichever setting they receive care. Instead of asking whether deteriorating residents are in the 'right place' to receive care, we might instead ask whether healthcare services are the 'right shape' to support to deteriorating care home residents and their complex needs.

Strategic Coding in the Assessment of Long-Term Care Needs: Evidence From France

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2025

Health Econ 34(6): 1035-1063.

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There is strong evidence of «upcoding» whereby health care providers overstate the severity of disease to increase billing revenue. Much less is known about strategic coding in the assessment of patient eligibility for long-term care. This paper takes advantage of a unique French linked survey dataset to document how patient assessment depends critically on the incentives of the assessing agents. I find that nursing homes assess their patients to be more disabled (thus increasing their revenue) compared to community assessors who seek to minimize disability payments levels. Public hospital-owned long-term care facilities are more likely to overrate disability levels; there is also evidence that cognitively impaired or socially disadvantaged patients exhibit more disability upcoding. In the context of nursing homes, upcoding might be read as «side-coding,» driven by flaws in the assessment tool that does not allow the care provider to adequately fund the time they spend on these patients. Conversely, assessors of patients living in the community could downcode disability to shift some of the care tasks to informal caregivers.

The burden of mental health and somatic disorders among people experiencing incarceration later in life: a 13-year cohort study

TVERBORGVIK, T., STAVSETH, M. R., LOKDAM, N. T., *et al.*

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Social Science & Medicine 373: 118007.

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Background The growing number of older incarcerated individuals presents unique challenges for prison systems, traditionally tailored for younger, healthier populations. Research on this demographic is crucial for informing effective health and correctional policies. Method Using data from the <BLINDED>, all people incarcerated at age 50 or older in Norway 2010-2022 were included. Study prevalence for selected disorders were calculated based on ICD-10 diagnoses registered in The Norwegian Patient Registry up until a person's last release date. One-year prevalence was calculated at prison entry each calendar year. Results Including 1120 women and 9667 men; 63% of women and 62% of men aged 50-64, and 70% of women and 75% of men aged 65+ were diagnosed with a somatic disorder. Among women, 63% (50-64 years) and 49% (65+ years) had a mental health disorder, as did 53% and 38% of the men. There were significant differences in diagnostic prevalence between sex and age groups. Thirty-eight percent of the population had comorbid diagnoses, higher among the youngest women (50–64 year: 46%). The one-year prevalence of individuals with mental disorders increased from 23% in 2010 to 34% in 2022, while the one-year prevalence of communicable and noncommunicable diseases remained consistent over time. Conclusions This study presents the first comprehensive description of the mental and somatic health burden of older individuals incarcerated in Norway. Our results underscore the urgent need for correctional and health services to implement tailored interventions that address the unique healthcare requirements of this aging population.

Impact of retirement transition on health, well-being and health behaviours: critical insights from an overview of reviews

VIGEZZI, G. P., BARBATI, C., MAGGIONI, E., *et al.*

2025

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Retirement is a pivotal life course transition wich may have profound implications for health, well-being and health behaviours. Despite extensive research and theoretical debate, the impact of retirement on health remains inconclusive, with studies reporting positive, negative, or no effects. This overview of reviews synthesises evidence from 15 systematic reviews (4 meta-analyses) assessing the relationship between retirement and physical and mental health outcomes (including mortality, mental health, cognitive decline and cardiovascular diseases) and health behaviours (including physical activity, diet, smoking and alcohol consumption). The review adheres to PRIOR guidelines and assesses the quality of the literature and existing methodological challenges. Findings indicate that retirement's impact varies widely depending on socioeconomic status (SES), job characteristics, and individual lifestyle factors. Retirees with higher SES generally experience improved mental health and increased physical activity, whereas those with lower SES are more prone to declines in physical and mental health, increased sedentary behaviour, and adverse cardiovascular outcomes. Evidence on cognitive decline and mortality remains mixed. This review highlights critical methodological issues in the existing literature, including inconsistent definitions of retirement, reliance on self-reported health data, and biases like reverse causality and healthy worker effects. Future research should prioritise life course longitudinal designs and cross-country comparisons informed by stronger theoretical grounding to untangle the complex relationship between retirement and health. Policy efforts should target vulnerable groups, particularly those from lower SES, by promoting physical activity, mental well-being, and social engagement during and after transition to retirement. Tailored interventions during the retirement transition could mitigate health disparities and improve overall well-being in later life.

Mental wellbeing and aging in place: The role of the built environment in promoting healthy aging

ZUMELZU, A., FIERRO, M. M. ET HERRMANN-LUNECKE, M. G.

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We analyze the built environment and its impacts on senior citizens' mental wellbeing. Through «Go-Along» method, 50 walking interviews were made to analyze the emotional experiences of elderly individuals in relation to the built environment. Results indicate that a highly walkable environment with local shops can generate a greater connection with the community, increasing individual tranquility and trust in public space. Natural elements like well-maintained gardens, consistent trees on sidewalks, varied tree leaf colors, and lush grass on streets positively influence seniors' mental wellbeing. These findings are crucial for urban design, offering valuable guidance to create inclusive environments that support healthy aging.

Index des auteurs
Author index