IRDES
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

Mars 2025 / March 2025

Assurance maladie	*Health Insurance*
Démographie	*Demography*
E-santé – Technologies médicales	*E-health – Medical Technologies*
Économie de la santé	*Health Economics*
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Méthodologie – Statistique	*Methodology - Statistics*
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Veille scientifique en économie de la santé / **Watch on Health Economics Literature**

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Health Insurance

Trends in Medicaid Take-Up Among Eligible Adults After the Affordable Care Act Medicaid Expansions: 2014-2019

ABDUS, S.

2025

Med Care Res Rev 82(1): 100-106.

https://doi.org/10.1177/10775587241273429

Little is known about how take-up of Medicaid among eligible adults has changed since 2014. This study used data from the Medical Expenditure Panel Survey to examine changes in Medicaid enrollment among Medicaid-eligible adults between 2014 and 2019. Eligibility for Medicaid was simulated using state- and year-specific eligibility rules. Among all Medicaid-eligible citizen adults aged 19-64 years, the proportion enrolled in Medicaid increased from 55.5% in 2014-2015 to 61.9% in 2016-2017, and then remained approximately at the same level in 2018-2019 (61.5%). Among adults who became eligible because of the Medicaid expansions, the proportion enrolled in Medicaid increased from 44.1% in 2014-2015 to 53.8% in 2016-2017. Among pre-Affordable Care Act (ACA)-eligible adults, there was no statistically significant change in the proportion enrolled in Medicaid between 2014-2015 and 2016-2017 (66.8% and 69.7%, respectively). There were significant differences in changes in take-up rates across population subgroups.

Health Benefits In 2024: Higher Premiums Persist, Employer Strategies For GLP-1 Coverage And Family-Building Benefits

CLAXTON, G., RAE, M., DAMICO, A., *et al.*

2024

Health Affairs 43(11): 1491-1501.

https://doi.org/10.1377/hlthaff.2024.01006

In 2024, the average annual premium for employer-sponsored family health coverage was $25,572, an increase of $1,604 (7 percent) from 2023. Over the course of the past five years, the average family premium has increased 24 percent, which is similar to growth seen in inflation (23 percent) and wages (28 percent). On average, covered workers contributed 16 percent ($1,368) of the cost of single coverage and 25 percent ($6,296) of the cost of family coverage. The average general annual deductible for single coverage for workers with a deductible was $1,787, similar to that in recent years but 47 percent higher than a decade ago. In 2024, 18 percent of large firms offering health benefits, including 28 percent of those with 5,000 or more employees, covered GLP-1 antagonists for weight loss. Large employers were more likely to perceive their overall provider networks as broader than their networks for mental health and substance use conditions.

Resumption Of Medicaid Eligibility Redeterminations: Little Change In Overall Insurance Coverage

GUPTA, S., BEHRER, C., WANG, V., *et al.*

2024

Health Affairs 43(11): 1518-1527.

https://doi.org/10.1377/hlthaff.2024.00641

In anticipation of the end of the COVID-19 public health emergency, Congress ended the Medicaid continuous coverage requirement on March 31, 2023, allowing states to terminate coverage for ineligible people and resume eligibility determinations through a process known as unwinding. Although administrative data have documented substantial declines in Medicaid enrollment since April 2023, the impact on uninsurance is unknown. Using data from the Census Bureau's Household Pulse Survey, we estimated the early effect of Medicaid unwinding on insurance coverage among people ages 19–64. We found that within the first three months of unwinding, the number of people self-reporting Medicaid coverage declined by approximately two million, and there was a much smaller, statistically insignificant decline in overall coverage of approximately 467,000 people. It appears that for many people, the availability of employer-sponsored insurance and other private coverage offset Medicaid coverage loss. These results suggest that the resumption of redeterminations has had less impact on uninsurance than was initially feared. Our findings highlight the importance of tracking coverage transitions during unwinding. By identifying populations at risk for uninsurance after Medicaid loss, these data could enhance the effectiveness of state outreach and enrollment assistance for people eligible for Marketplace coverage and subsidies.

Medicare Advantage Plans With High Numbers Of Veterans: Enrollment, Utilization, And Potential Wasteful Spending

MA, Y., PHELAN, J., JEONG, K. Y., *et al.*

2024

Health Affairs 43(11): 1508-1517.

https://doi.org/10.1377/hlthaff.2024.00302

Medicare Advantage (MA) plans are increasingly enrolling veterans. Because MA plans receive full capitated payments regardless of whether or not veterans use Medicare services, the federal government can incur substantial duplicative, wasteful spending if veterans in MA plans predominantly seek care through the Veterans Health Administration (VHA) system. The recent growth of MA plans that disproportionately enroll veterans could further exacerbate such wasteful spending. Using national data, we found that veterans increasingly enrolled in MA between 2016 and 2022, including in a growing number of MA plans in which 20 percent or more of the enrollees were veterans. Notably, about one in five VHA enrollees in these high-veteran MA plans did not incur any Medicare services paid by MA within a given year—a rate 2.5 times that of VHA enrollees in other MA plans and 5.7 times that of the general MA population. Meanwhile, VHA enrollees in high-veteran MA plans were significantly more likely to receive VHA-funded care. In 2020, the Centers for Medicare and Medicaid Services paid more than $1.32 billion to MA plans for VHA enrollees who did not use any Medicare services, with 19.1 percent going to high-veteran MA plans.

How Specialized Are Special Needs Plans? Evidence From Provider Networks

MCCORMACK, G., WU, R. ET MEISELBACH, M.

2025

Medical Care Research and Review 82(1): 58-67.

https://doi.org/10.1177/10775587241296194

Enrollment in Medicare Advantage (MA) Dual-Eligible Special Needs Plans (D-SNPs) among individuals dually eligible for Medicare and Medicaid has more than tripled over the past decade. Little is known about whether D-SNP plan design differs from standard MA plan design nor whether this design reflects the needs of dual-eligible enrollees. We characterize the degree to which D-SNPs specialize in an important plan design dimension—provider networks. We find that in 2022, 46% of D-SNPs offer networks that are distinct from the insurer's standard MA plan networks. Compared with D-SNP networks that are shared with standard MA plans, specialized D-SNP networks include more psychiatrists, Ob/Gyn's, and neurologists, providers that specialize in treating conditions more common among dually eligible enrollees. Network specialization is more common among insurers participating in the local Medicaid market and less common in provider shortage areas, suggesting investment in Medicaid and reduced provider negotiation costs may facilitate specialization.

Impact of the Affordable Care Act on access to accredited facilities for cancer treatment

SABIK, L. M., KWON, Y., DRAKE, C., *et al.*

2024

Health Services Research 59(6): e14315.

https://doi.org/10.1111/1475-6773.14315

Abstract Objective To examine differential changes in receipt of surgery at National Cancer Institute (NCI)-designated comprehensive cancer centers (NCI-CCC) and Commission on Cancer (CoC) accredited hospitals for patients with cancer more likely to be newly eligible for coverage under Affordable Care Act (ACA) insurance expansions, relative to those less likely to have been impacted by the ACA. Data Sources and Study Setting Pennsylvania Cancer Registry (PCR) for 2010–2019 linked with discharge records from the Pennsylvania Health Care Cost Containment Council (PHC4). Study Design Outcomes include whether cancer surgery was performed at an NCI-CCC or a CoC-accredited hospital. We conducted a difference-in-differences analysis, estimating linear probability models for each outcome that control for residence in a county with above median county-level pre-ACA uninsurance and the interaction between county-level baseline uninsurance and cancer treatment post-ACA to capture differential changes in access between those more and less likely to become newly eligible for insurance coverage (based on area-level proxy). All models control for age, sex, race and ethnicity, cancer site and stage, census-tract level urban/rural residence, Area Deprivation Index, and year- and county-fixed effects. Data Collection/Extraction Methods We identified adults aged 26–64 in PCR with prostate, lung, or colorectal cancer who received cancer-directed surgery and had a corresponding surgery discharge record in PHC4. Principal Findings We observe a differential increase in receiving care at an NCI-CCC of 6.2 percentage points (95% CI:

2.6–9.8; baseline mean = 9.8%) among patients in high baseline uninsurance areas (p = 0.001). Our estimate of the differential change in care at the larger set of CoC hospitals is positive (3.9 percentage points [95% CI: –0.5-8.2; baseline mean = 73.7%]) but not statistically significant (p = 0.079). Conclusions Our findings suggest that insurance expansions under the ACA were associated with increased access to NCI-CCCs.

E-Santé - Technologies médicales

E-Health-Medical Technologies

▶ The impact of telehealth cost-sharing on healthcare utilization: Evidence from high-deductible health plans

GIDWANI, R., YANK, V., BURGETTE, L., *et al.*
2024
Health Services Research 59(6): e14343.
https://doi.org/10.1111/1475-6773.14343

Abstract Objective Evaluate whether cost-sharing decreases led high-deductible health plans (HDHP) enrollees to increase their use of healthcare. Data Sources, Study Setting National sample of chronically-ill patients age 18–64 from 2018 to 2020 (n = 1,318,178). Study Design Difference-in-differences analyses using entropy-balancing weights were used to evaluate the effect of a policy shift to $0 cost-sharing for telehealth on utilization for HDHP compared with non-HDHP enrollees. Due to this shock, HDHP enrollees experienced substantial declines in cost-sharing for telehealth, while non-HDHP enrollees experienced small declines. Event study models were also used to evaluate changes over time. Data Collection/Extraction Methods Outcomes included use of any outpatient care; use of $0 telehealth; use of $0 telehealth as a proportion of all outpatient care; and use of any telehealth. To test whether any differences were due to preferences for care modality versus cost-sharing, we further evaluated use of non-$0 telehealth as a placebo test. Principal Findings There was no difference in change in overall outpatient visits (p = 0.84), with chronically-ill HDHP enrollees using less care both before and after the policy shift. However, compared with non-HDHP enrollees, HDHP enrollees increased their use of $0 telehealth by 0.08 visits over a 9-month period, a 27% increase (95% CI 0.07–0.09, p < 0.001) and shifted 1.2 percentage points more of their care to $0 telehealth, a 15% increase (ß = 0.01, 95% CI 0.01, 0.01, p < 0.001). However, HDHP enrollees had lower uptake of non-$0 telehealth than non-HDHP enrollees (ß = –0.01, 95%CI –0.02, 0.00, p = 0.04). Conclusions Recent-but-expiring federal legislation exempts telehealth from HDHP deductibles for care provided in 2023 and 2024. Our results indicate that extending the protections provided by this legislation could help reduce the gap in access to care for chronically-ill persons enrolled in HDHPs.

▶ Reforming Physician Licensure in the United States to Improve Access to Telehealth: State, Regional, and Federal Initiatives

JOLIN, J. R., RICHMAN, B., MEHROTRA, A., *et al.*
2024
The Milbank Quarterly 102(4): 833-852.
https://doi.org/10.1111/1468-0009.12713

Policy Points The reinstitution of pre–COVID-19 pandemic licensure regulations has impeded interstate telehealth. This has disproportionately impacted patients who live near a state border; geographically mobile patients, such as college students; and patients with rare diseases who may need care from a specialist outside their state. Several promising and feasible reforms are available, at both state and federal levels, to facilitate interstate telehealth. For example, states can offer exemptions to licensure requirements for certain types of telehealth such as follow-up care or create licensure registries that impose little reduced paperwork and fees on physicians. On the federal level, congressional interventions that mimic the Department of Veterans Affairs Maintaining Internal Systems and Strengthening Integrated Outside Networks (VA MISSION) Act of 2018 can waive provider licensing and geographic restrictions to telehealth within certain federal programs such as Medicare. Any discussion of medical licensure reform, however, must also consider the current political climate, one in which states are taking divergent stances on sensitive topics such as reproductive care, gender-affirming care, and substance use treatments.

Are EU member states ready for the European Health Data Space? Lessons learnt on the secondary use of health data from the TEHDAS Joint Action

KESSISSOGLOU, I. A., COSGROVE, S. M., ABBOUD, L. A., *et al.*

2024

European Journal of Public Health 34(6): 1102-1108.

https://doi.org/10.1093/eurpub/ckae160

The proposal for a regulation on the European Health Data Space (EHDS) contains provisions that would significantly change health data management systems in European member states (MS). This article presents results of a country mapping exercise conducted during the Joint Action 'Towards the European Health Data Space' (TEHDAS) in 2022. It presents the state-of-play of health data management systems in 12 MS and their preparedness to comply with the EHDS provisions. The country mapping exercise consisted of virtual or face-to-face semi-structured interviews to a selection of key stakeholders of the health information systems. A semi-quantitative analysis of the reports was conducted and is presented here, focusing on key aspects related to the user journey through the EHDS. This article reveals a heterogenous picture in countries' readiness to comply with the EHDS provisions. There is a need to improve digitalization and quality of health data at source across most countries. Less than half of the countries visited have or are developing a national datasets catalogue. Although the process to access health data varies, researchers can analyse health data in secure processing environments in all countries visited. Most of the countries use a unique personal identifier for health to facilitate data linkage. The study concluded that the current landscape is heterogeneous, and no member state is fully ready yet to comply with the future regulation. However, there is general political will and ongoing efforts to align health data management systems with the provisions in the EHDS legislative proposal.

Enjeux d'éthique du numérique et de l'IA en santé

KIRCHNER, C.

2025

Bulletin de l'Académie Nationale de Médecine 209(1): 57-61.

https://doi.org/10.1016/j.banm.2024.06.028

Résumé L'éthique de la biomédecine numérique n'est pas juste une combinaison des éthiques du numérique et de la biomédecine. Elle nécessite une réflexion intégrative prenant en compte les interactions profondes entre ces deux disciplines et leurs impacts combinés sur les conduites humaines et les valeurs qui les fondent. Dans cette courte revue des enjeux d'éthique du numérique et de l'IA en santé, nous reprenons les points qui ont été développés récemment dans le contexte d'évolution rapide et radicale de la combinaison résultant de ces deux disciplines. Summary The ethics of digital biomedicine is not just a combination of digital and biomedical ethics. It requires integrative thinking that takes into account the deep interactions of these two disciplines and their combined impacts on human behaviour and the values that underpin it. In this short review of the ethical challenges of digital technology and AI in healthcare, we take up the points that have been developed recently in a context of rapid and radical evolution of the resulting combination of these two disciplines.

Quels apports le métavers pourrait-il amener aux systèmes de santé ?

MULUMBA, B. K., BRUNET, F. ET POMEY, M. P.

2024

Santé Publique 36(6): 43-49.

https://stm.cairn.info/revue-sante-publique-2024-6-page-43

Les systèmes de santé sont confrontés à des enjeux majeurs qui les mettent sous tension pour répondre correctement aux attentes des usagers. Il s'agit notamment de la complexification de l'accès aux ressources humaines qualifiées et des limites des ressources financières qui peuvent être investies. À ce titre, le métavers peut trouver des solutions à ces défis. Dans ce texte, nous abordons les champs d'application et apports possibles du métavers dans les systèmes de santé. Les champs d'application comprennent la formation pour renforcer les compétences des professionnels de la santé, la dispensation de soins pour améliorer la qualité des services, la communication pour faciliter le partage d'information entre les différentes parties prenantes, et la recherche pour optimiser l'adhésion et la sécurité des participants. Toutefois, le métavers peut aussi avoir des effets négatifs sur les personnes qui l'utilisent autant que sur celles qui en bénéficient. Il s'agit notamment de la cybercriminalité et de l'atteinte de la santé physique, mentale et sociale. Des recherches évaluatives sont donc nécessaires pour mesurer l'étendue et les conditions de son applicabilité.

Examining the Inclusion of Trust and Trust-Building Principles in European Union, Italian, French, and Swiss Health Data Sharing Legislations: A Framework Analysis

ZAVATTARO, F., VON WYL, V. ET GILLE, F.

2024

The Milbank Quarterly 102(4): 973-1003.

https://doi.org/10.1111/1468-0009.12722

Policy Points First, policymakers can strengthen the inherent trust-building effect of legislations on citizens by incorporating trust-building principles within health data-sharing legislations in a recognizable and comprehensive manner to explicitly signal public trust to policy implementers as one of the policy outcomes to be achieved in the implementation phase. Second, policymakers can use the proposed "public trust in health data sharing" framework as an initial guide to incorporate trust-building principles within health data-sharing legislations. Context Public trust is critical to both system legitimacy and the successful implementation of data-driven health initiatives. Legislations are an essential instrument for building public trust, as they can have a dual effect on trust: a passive effect by reinforcing the public perception of an active regulatory system that upholds the rule of law and an active effect as a tool for policymakers to signal trust-building actions to be undertaken during the implementation phase. However, there is limited evidence on the extent to which health data-sharing legislations contain references to trust and trust-building principles for their practical implementation. Methods By applying an evidence-based "public trust in health data sharing" framework, 36 legislations from the European Union (EU), Italy, France, and Switzerland on health data sharing were analyzed to assess 1) how the term "trust" is embedded in legislations, and 2) the presence and quality of trust-building principles within the selected legislations. Findings Nine legislations incorporated references to "trust," mainly within the explanatory memorandum and preambles of EU legislations. The most prevalent trust-building principles were "agencies of accountability" (72%) and data "security" (70%). In contrast, the principles "public information" (14%) and "time" (6%) were the least presented. Moreover, the qualitative analysis showed that the majority of the trust-building principles were implicit in the legal text, with Swiss legislations having the highest number of explicit references. Conclusions The limited and implicit use of "trust" and trust-building principles in EU, Italian, French, and Swiss legislation emphasizes the opportunity to raise policymakers' awareness of these principles. The proposed framework provides an initial guide for policymakers to incorporate trust-building principles within health data-sharing legislations in a recognizable and comprehensive manner. This ensures that policy implementers at various stages of the policy process can implement trust-building actions, contributing to public trust building in both European and national health data-sharing initiatives.

Économie de la santé

Health Economics

Investigation of the health economic analysis of informal care for people living with a chronic neurological disease: A systematic review and meta-analysis of the global evidence for multiple sclerosis

ADAL, T. G., VAN DER MEI, I., TAYLOR, B. V., *et al.*

2024

Social Science & Medicine 363: 117405.

https://doi.org/10.1016/j.socscimed.2024.117405

ABSTRACT Multiple sclerosis (MS) is a chronic neurological disease that causes substantial health economic impacts, however, the cost of informal care for MS is often excluded from health economic analysis. As a result there is a paucity of information for decision-making. This review aims to summarise, synthesise and where appropriate meta-analyse the global evidence regarding the health economics of informal care for people with MS. The findings will provide consolidated evidence that policymakers and other stakeholders can use to inform decisions, including the development of health economics models. This review was conducted with a pre-determined study protocol (PROSPERO- CRD42023396457). Biomedical and economic databases were searched. Costs were converted to 2022 United States dollars (USD). Mean cost was calculated and pooled with a random-effects model. Subgroup analysis and meta-regression was conducted for stratified variables such as country income level and Expanded Disability Status Scale (EDSS). Of 6,306 identified studies, 61 were retained for narrative synthesis and 50 for meta-analysis. Studies were conducted in 25 countries. Cost information was collected from the person with MS, not the caregiver. 83.6% of studies used the opportunity cost method. Average monthly caregiving time was 60.1 hours. Informal care costs accounted for 15% of total societal cost of MS. Pooled mean annual cost of informal care per person was USD $6,308 (95% CI $5,022-7,594). Informal care costs were USD $6,797 and $1,478 in high- and middle-income countries. Costs for mild, moderate, and severe disability of the person with MS were $1,123, $6,643, and $15,855, respectively. Informal care cost contributes considerably to MS-related costs. Despite study heterogeneity, cost of informal care increases with MS-related disability severity, time attributed to care and country income level. These results can be used to inform health economic models for reimbursement decisions for MS. Future studies regarding the health economic burden of informal care should gather the data from the informal carers themselves.

Dégradation des comptes publics : Quelles conséquences pour le financement de la santé ?

AMRI, K.

2024

Gestions hospitalières 2024(639): 482-488.

Le « quoi qu'il en coûte ! », faisant suite pour partie à la crise sanitaire liée à l'épidémie de coronavirus, semble manifestement toujours peser sur la situation financière macroéconomique de notre pays. L'année 2023 en subit en effet les conséquences en matière de finances publiques, avec un déficit public qui s'est établi à 5,5 points de PIB. Quelles en sont les conséquences sur le financement des acteurs de santé ?

RAC en vrac

APOLLIS, B.

2024

Sève : les Tribunes de la santé(81): 55-62.

https://www.jle.com/10.1684/tsa.2024.33

Doublement des franchises médicales, tentatives d'instauration d'une « taxe lapin », velléités actuelles d'augmenter le ticket modérateur de certaines prises en charge, le débat sur les restes à charge (RAC) est intense depuis 2023. Sur le plan juridique, celui-ci réclame d'abord une analyse des dispositions récentes relatives aux RAC comme de celles qui finalement n'ont pas été prises. Il s'agit aussi de pointer le fait que le contrôle juridictionnel des actes portant sur les RAC s'avère de trop faible portée pour en limiter la multiplication.

Design and Features of Pricing and Payment Schemes for Health Technologies: A Scoping Review and a Proposal for a Flexible Need-Driven Classification

ARDITO, V., CIANI, O. ET DRUMMOND, M.

2025

PharmacoEconomics 43(1): 5-29.

https://doi.org/10.1007/s40273-024-01435-2

In a context of growing clinical and financial uncertainty, pricing and payment schemes can act as possible solutions to the problems of affordability and access to health technologies. However, a comprehensive categorization of the available schemes to help decision makers tackle these challenges is lacking. This work aims at mapping existing types of pricing and payment schemes, and proposes a new approach for their classification, in order to help decision makers and other stakeholders select the best type of scheme to meet their needs.

Financiarisation et professions de santé

CORMIER, M.

2024

Revue de droit sanitaire et social (Hors série): 65-87.

Cet article analyse la tendance à la financiarisation des professionnels de santé en examinant successivement le phénomène de marée de la financiarisation montante et la levée du vent de la révolte. Cette métaphore illustre ce double mouvement d'accélération et de réaction récente des pouvoirs publics et des ordres professionnels visant à le contrôler et à l'encadrer.

Biological age and predicting future health care utilisation

DAVILLAS, A. ET JONES, A. M.

2024

Journal of Health Economics 99: 102956.

https://doi.org/10.1016/j.jhealeco.2024.102956

We explore the role of epigenetic biological age in predicting subsequent health care utilisation. We use longitudinal data from the UK Understanding Society panel, capitalising on the availability of baseline epigenetic biological age measures along with data on general practitioner (GP) consultations, outpatient (OP) visits, and hospital inpatient (IP) care collected 5-12 years from baseline. Using least absolute shrinkage and selection operator (LASSO) regression analyses and accounting for participants' pre-existing health conditions, baseline biological underlying health, and socio-economic predictors we find that biological age is selected as a predictor of future GP consultations and IP care, while chronological rather than biological age is selected for future OP visits. Post-selection prediction analysis and Shapley-Shorrocks decompositions, comparing our preferred prediction models to models that replace biological age with chronological age, suggest that biological ageing has a stronger role in the models predicting future IP care as opposed to "gatekeeping" GP consultations.

Réduire les disparités et les coûts pour les finances publiques : vers un secteur public du *care*

DEVETTER, F. X., PUCCI, M. ET VALENTIN, J.

2024

Revue de l'Ires(112-113): 75-115.

https://ires.fr/publications/la-revue-de-l-ires/n112-113/reduire-les-disparites-et-les-couts-pour-les-finances-publiques-vers-un-secteur-public-du-care/

Les services de prise en charge de la petite enfance et de la perte d'autonomie sont de plus en plus reconnus comme devant faire l'objet d'un « service public », au sens où ils renvoient à des besoins sociaux considérés comme légitimes. Cet article se propose d'évaluer ce qu'il en coûterait, du point de vue des finances publiques, de substituer à l'organisation actuelle une organisation reposant sur une fonction publique du *care* permettant d'homogénéiser non seulement les conditions d'emploi mais également l'accès à ces services sur le territoire. Nous montrons que pour offrir, dans le champ de la petite enfance et celui du grand âge, un taux de service identique à celui du 10^{e} département le mieux doté, 183 000 emplois supplémentaires sont à créer, ce qui coûterait 7,9 milliards d'euros. À travers ces estimations nous montrons que les coûts de l'organisation actuelle sont déjà largement supportés par les finances publiques et que l'affirmation d'un secteur public du *care* ne constituerait pas un investissement disproportionné.

Is It Possible To Pay For More Equitable Health Outcomes?

GERBER, M. S.

2024

Health Affairs 43(11): 1485-1490.
https://doi.org/10.1377/hlthaff.2024.01067

Payers in Massachusetts hope to use the principles of value-based care and pay-for-performance to reduce health care disparities.

La réforme du financement de la radiothérapie : Quels enjeux pour la lutte contre le cancer ?

LARTIGAU, E., BEAUPERE, S. ET BOUCHER, S.

2024

Gestions hospitalières 2024(639): 514-515.

Spécialité médicale de traitement du cancer, la radiothérapie se distingue par des modalités de financement très différentes entre les hôpitaux anciennement sous dotation globale et les cabinets libéraux. L'objectif de la réforme du financement de l'activité est d'aller vers une tarification au forfait et d'encourager les innovations au bénéfice des patients.

Equity in healthcare financing: a review of evidence

LUYTEN, E. ET TUBEUF, S.

2024

Health Policy 152: 105218.
https://doi.org/10.1016/j.healthpol.2024.105218

This review summarises empirical studies on the progressivity and redistributive effects of healthcare financing mechanisms. The evidence varies significantly across countries and financing sources. Tax-based systems exhibit high progressivity, as direct taxes contribute to a favourable redistribution toward low-income households, often offsetting the regressive nature of indirect taxes. Social insurance systems are found to be progressive but may be regressive in practice due to contribution ceilings and exemptions for high-income earners. This creates disparities where high-income taxpayers benefit from social protection while contributing less proportionally to their total income, limiting the overall positive redistributive effect on income inequalities. Most health systems with co-payments use flat rates rather than income-based rates, disproportionately affecting lower-income individuals and potentially leading to catastrophic expenses. This review highlights a lack of recent research on healthcare financing in high-income countries, while recent studies in low- and middle-income countries align with commitment to deliver universal health coverage. Continuous analysis of the redistributive effects of the health system is essential to ensure that health financing systems not only fund healthcare effectively but also contribute to broader social equity goals.

Regards croisés sur l'évolution de la protection sociale en France depuis la fin du XIXe siècle. Avant-propos

MAREC, Y., VALAT, B. ET VIET, V.

2024

Revue Française des Affaires Sociales N° 244(4)
https://shs.cairn.info/revue-francaise-des-affaires-sociales-2024-4-page-8

À travers un long avant-propos et quatre articles de synthèse, ce quatrième numéro entend montrer à la fois la diversité de notre système de protection sociale et la pluralité des approches historiques. Ce quatrième numéro de 2024 de la Revue française des affaires sociales est consacré à l'histoire de la protection sociale depuis la fin du XIXe siècle. À travers un long avant-propos et quatre articles de synthèse, il entend montrer à la fois la diversité de notre système de protection sociale et la pluralité des approches historiques.

National Health Expenditures In 2023: Faster Growth As Insurance Coverage And Utilization Increased

MARTIN, A. B., HARTMAN, M., WASHINGTON, B., *et al.*

2025

Health Affairs 44(1): 12-22.
https://doi.org/10.1377/hlthaff.2024.01375

Health care spending in the US reached $4.9 trillion and increased 7.5 percent in 2023, growing from a rate of 4.6 percent in 2022. In 2023, the insured share of the population reached 92.5 percent, as enrollment in private health insurance increased at a strong rate for the second year in a row, and both private health insurance and Medicare spending grew faster than in 2022. For Medicaid, spending and enrollment growth slowed as the COVID-19 public health emergency ended. The health sector's share of the economy in 2023 was 17.6 percent, which was similar to its share of 17.4 percent in 2022 but lower than in 2020 and 2021, during the height of the COVID-19 pandemic. State and local governments accounted for a higher share of spending in 2023 than in 2022, while the federal government share was lower as COVID-19-related funding declined and federal Medicaid spending growth slowed.

▶ A Framework for the Design of Risk-Adjustment Models in Health care Provider Payment Systems

PANTURU, A., VAN KLEEF, R., EIJKENAAR, F., *et al.*

2025

Medical Care Research and Review 82(1): 43-57.

https://doi.org/10.1177/10775587241273355

Prospective payments for health care providers require adequate risk adjustment (RA) to address systematic variation in patients' health care needs. However, the design of RA for provider payment involves many choices and difficult trade-offs between incentives for risk selection, incentives for cost control, and feasibility. Despite a growing literature, a comprehensive framework of these choices and trade-offs is lacking. This article aims to develop such a framework. Using literature review and expert consultation, we identify key design choices for RA in the context of provider payment and subsequently categorize these choices along two dimensions: (a) the choice of risk adjusters and (b) the choice of payment weights. For each design choice, we provide an overview of options, trade-offs, and key references. By making design choices and associated trade-offs explicit, our framework facilitates customizing RA design to provider payment systems, given the objectives and other characteristics of the context of interest.

▶ Cross-country comparisons in health price growth over time.

PAPANICOLAS, I., CYLUS, J. ET LORENZONI, L.

2024

Health Services Research 59(6): e14295.

https://doi.org/10.1111/1475-6773.14295

Abstract Objective To examine how the United States compares in terms of health price growth relative to four other countries - Australia, Canada, France, and the Netherlands. Data Sources and Study Setting Secondary data on health expenditure were extracted from international and national agencies spanning the years 2000–2020. Study Design International price indices specific to health were constructed using available international expenditure data and compared to existing health-specific national and general international price indices. Data Collection/Extraction Methods Health expenditure data were extracted from the Organization for Economic Cooperation and Development (OECD) database. We obtained a time series of health price indices from the national agencies in each of the study countries. Principal Findings We find meaningful variation across countries in the rate at which health prices grow relative to general prices. The United States had the highest cumulative health price growth compared to general price growth over the years 2000–2020 at 14%, followed by Canada and the Netherlands. Unlike the other study countries, health prices in France grew consistently in line with general prices. Price growth for health care paid for by public funds and households grew at different rates across countries, where price growth was higher for public payers. US households faced the greatest mean annual price growth. Conclusions The choice of price index has major implications for comparative analysis. Despite their widespread use internationally, general price indices likely underestimate the contribution of price growth to overall health expenditure growth. We find that in addition to its reputation for having high health price levels compared to other high-income countries, the United States also faces health price growth for goods and services paid for by government and households in excess of general price growth. Furthermore, US households are exposed to greater health price growth than households in comparator countries.

▶ Adjusting the risk-adjustment: Accounting for variation between organisations in the responsiveness of their expenditure to need

URWIN, S., ANSELMI, L., MENTZAKIS, E., *et al.*

2024

Social Science & Medicine 361: 117346.

https://doi.org/10.1016/j.socscimed.2024.117346

There is concern that basing healthcare budgets on risk adjustment estimates derived from historical utilisation data may reinforce patterns of unmet need. We propose a method to avoid this, based on a measure of how closely local health organisations align resources to the needs of their populations. We refer to this measure as the 'responsiveness of expenditure to need' and estimate it using national person-level data on use of acute hospital and secondary mental health services in England. We find large variation in responsiveness in both services and show that higher expenditure responsiveness in mental health is associated with fewer suicides. We then re-estimate the national risk-adjustment model removing the data from the organisations with the lowest expenditure responsiveness to need. As expected, higher need individuals are estimated to have higher expenditure needs when less responsive organisations are removed from the estimation of the risk-adjustment. Removal of organisations with below-average responsiveness results in the neediest deciles of individuals having an extra £163 (7%) annual need for acute hospital care and an additional £79 (27%) annual need for mental health services. The application of this approach to risk adjustment would result in more resources being directed towards organisations serving higher-need populations.

Estimating the Incremental Cost Per QALY Produced by the Spanish NHS: A Fixed-Effect Econometric Approach

VALLEJO-TORRES, L.

2025

PharmacoEconomics 43(1): 109-122.

https://doi.org/10.1007/s40273-024-01441-4

Knowing the health opportunity costs of funding decisions is crucial to assess whether the health gains associated with new interventions are larger than the health losses imposed by the displacement of resources. Empirical estimates based on the effect of health spending on health outcomes have been proposed in several countries, including Spain, as a proxy to capture these opportunity costs. However, there is a need to regularly update existing health opportunity cost estimates and to explore the role of omitted variable bias in these estimations.

Moral hazard and risk adjustment

ZWART, G.

2025

J Health Econ 99: 102955.

https://doi.org/10.1016/j.jhealeco.2024.102955

We analyse a model of optimal risk adjustment in competitive health-insurance markets which suffer from both ex-ante adverse selection and ex-post moral hazard. We find, firstly, that, unlike in an adverse-selection-only market, in an environment where also moral hazard is important, removing insurers' selection incentives requires risk-adjustment payments that do not fully equalize costs among consumer types. Current practice of attempting to correct for all predictable cost differences among consumers is then misguided. Secondly, if the sponsor of the risk-adjustment system is not only concerned with eliminating selection distortions, but also wants to redistribute towards high-risk consumers, the required higher risk-adjustment payments will introduce selection distortions in high-risk consumers' contracts. This leads to excessive equilibrium provision of care for those suffering severe health shocks. Finally, insurer market power creates countervailing incentives, helping the risk adjuster to combat selection distortions but working against a risk-adjustment regulation that also cares about redistribution.

Environnement de la santé

Environnemental Health

Understanding excess mortality in 2022: The dual impact of COVID-19 and heatwaves on the Italian elderly population

CECCARELLI, E., MINELLI, G., MARUOTTI, A., *et al.*

2024

Health & Place 90: 103357.

https://doi.org/10.1016/j.healthplace.2024.103357

In this study, we employ a comprehensive approach to model the concurrent effects of the COVID-19 epidemic and heatwaves on all-cause excess mortality. Our investigation uncovers distinct peaks in excess mortality, notably among individuals aged 80 years and older, revealing a strong positive correlation with excess temperatures (ET) during the summer of 2022 in Italy. Furthermore, we identify a notable role played by COVID-19 hospitalizations, exhibiting regional disparities, particularly during the winter months. Leveraging functional data regression, we offer robust and coherent insights into the excess mortality trends observed in Italy throughout 2022.

Estimated Carbon Savings from Changing Surgical Trends in Primary Elective Total Hip Arthroplasty in England: A Retrospective Observational Study

KORIS, J., OJELADE, E., BEGUM, H., *et al.*

2025

Applied Health Economics and Health Policy 23(1): 85-92.

https://doi.org/10.1007/s40258-024-00916-x

The National Health Service (NHS) in England has set a target to be net zero for carbon emissions by 2045. The aim of this study was to investigate how changes in key aspects of clinical practice over the last 8 years have contributed towards reducing the per-patient carbon footprint of elective total hip arthroplasty (THA).

Moving from features to functions: Bridging disciplinary understandings of urban environments to support healthy people and ecosystems

YUILLE, A., DAVIES, J., GREEN, M., *et al.*

2024

Health & Place 90: 103368.

https://doi.org/10.1016/j.healthplace.2024.103368

Contact with nature can contribute to health and wellbeing, but knowledge gaps persist regarding the environmental characteristics that promote these benefits. Understanding and maximising these benefits is particularly important in urban areas, where opportunities for such contact is limited. At the same time, we are facing climate and ecological crises which require policy and practice to support ecosystem functioning. Policies are increasingly being oriented towards delivering benefits for people and nature simultaneously. However, different disciplinary understandings of environments and environmental quality present challenges to this agenda. This paper highlights key knowledge gaps concerning linkages between nature and health. It then describes two perspectives on environmental quality, based respectively in environmental sciences and social sciences. It argues that understanding the linkages between these perspectives is vital to enable urban environments to be planned, designed and managed for the benefit of both environmental functioning and human health. Finally, it identifies key challenges and priorities for integrating these different disciplinary perspectives.

État de santé

Health Status

The effect of parental health shocks on living arrangements and employment

BERGEOT, J., FERRARI, I. ET GAO, Y.

2024

Health Economics 33(12): 2798-2837.

https://doi.org/10.1002/hec.4893

Abstract This study investigates the impacts of health shocks among older individuals on the dynamics of their living arrangements in Europe and the United States. Exploiting unpredicted health shocks, we use an event-study difference-in-differences approach to demonstrate that health shocks increase difficulties with activities of daily living and instrumental activities of daily living, thereby increasing the need for care. Our findings indicate that health shocks raise the probability of nursing home residency and co-residence with adult children by 0.7 and 1.4 percentage points in Europe, and by 2.1 and 1.8 percentage points in the U.S., respectively. Further analyses reveal that more generous long-term care public policies correlate with a higher probability of nursing home residency and a lower probability of co-residing with adult children, highlighting the significant role of public policies in household responses to health shocks. Additionally, we find that health shocks negatively impact adult children’s labor supply, particularly in the U.S.

Worldwide trends in diabetes prevalence and treatment from 1990 to 2022: a pooled analysis of 1108 population-representative studies with 141 million participants

NCD RISK FACTOR COLLABORATION (NCD-RISC)

2024

Lancet 404(10467): 2077-2093.

https://doi.org/10.1016/s0140-6736(24)02317-1

BACKGROUND: Diabetes can be detected at the primary health-care level, and effective treatments lower the risk of complications. There are insufficient data on the coverage of treatment for diabetes and how it has changed. We estimated trends from 1990 to 2022 in diabetes prevalence and treatment for 200 countries and territories. METHODS: We used data from 1108 population-representative studies with 141 million participants aged 18 years and older with measurements of fasting glucose and glycated haemoglobin (HbA(1c)), and information on diabetes treatment. We defined diabetes as having a fasting plasma glucose (FPG) of 7.0 mmol/L or higher, having an HbA(1c) of 6.5% or higher, or taking medication for diabetes. We defined diabetes treatment as the proportion of people with diabetes who were taking medication for diabetes. We analysed the data in a Bayesian hierarchical meta-regression model to estimate diabetes prevalence and treatment. FINDINGS: In 2022, an estimated 828 million (95% credible interval [CrI] 757-908) adults (those aged 18 years and older) had diabetes, an increase of 630 million (554-713) from 1990. From 1990 to 2022, the age-standardised prevalence of diabetes increased in 131 countries for women and in 155 countries for men with a posterior probability of more than 0.80. The largest increases were in low-income and middle-income countries in southeast Asia (eg, Malaysia), south Asia (eg, Pakistan), the Middle East and north Africa (eg, Egypt), and Latin America and the Caribbean (eg, Jamaica, Trinidad and Tobago, and Costa Rica). Age-standardised prevalence neither increased nor decreased with a posterior probability of more than 0.80 in some countries in western and central Europe, sub-Saharan Africa, east Asia and the Pacific, Canada, and some Pacific island nations where prevalence was already high in 1990; it decreased with a posterior probability of more than 0.80 in women in Japan, Spain, and France, and in men in Nauru. The lowest prevalence in the world in 2022 was in western Europe and east Africa for both sexes, and in Japan and Canada for women, and the highest prevalence in the world in 2022 was in countries in Polynesia and Micronesia, some countries in the Caribbean and the Middle East and north Africa, as well as Pakistan and Malaysia. In 2022, 445 million (95% CrI 401-496) adults aged 30 years or older with diabetes did not receive treatment (59% of adults aged 30 years or older with diabetes), 3.5 times the number in 1990. From 1990 to 2022, diabetes treatment coverage increased in 118 countries for women and 98 countries for men with a posterior probability of more than 0.80. The largest improvement in treatment coverage was in some countries from central and western Europe and Latin America (Mexico, Colombia, Chile, and Costa Rica), Canada, South Korea, Russia, Seychelles, and Jordan. There was no increase in treatment coverage in most countries in sub-Saharan Africa; the Caribbean; Pacific island nations; and south, southeast, and central Asia. In 2022, age-standardised treatment coverage was lowest in countries in sub-Saharan Africa and south Asia, and treatment coverage was less than 10% in some African countries. Treatment coverage was 55% or higher in South Korea, many high-income western countries, and some countries in central and eastern Europe (eg, Poland, Czechia, and Russia), Latin America (eg, Costa Rica, Chile, and Mexico), and the Middle East and north Africa (eg, Jordan, Qatar, and Kuwait). INTERPRETATION: In most countries, especially in low-income and middle-income countries, diabetes treatment has not increased at all or has not increased sufficiently in comparison with the rise in prevalence. The burden of diabetes and untreated diabetes is increasingly borne by low-income and middle-income countries. The expansion of health insurance and primary health care should be accompanied with diabetes programmes that realign and resource health services to enhance the early detection and effective treatment of diabetes. FUNDING: UK Medical Research Council, UK Research and Innovation (Research England), and US Centers for Disease Control and Prevention.

Global Healthspan-Lifespan Gaps Among 183 World Health Organization Member States

GARMANY, A. ET TERZIC, A.

2024

JAMA Network Open 7(12): e2450241-e2450241.

https://doi.org/10.1001/jamanetworkopen.2024.50241

Health-adjusted life expectancy, a measure of healthy longevity, lags longevity gains, resulting in a healthspan-lifespan gap. To quantify the healthspan-lifespan gap across the globe, investigate for sex disparities, and analyze morbidity and mortality associations. This retrospective cross-sectional study used the World Health Organization (WHO) Global Health Observatory as the global data source and acquired national-level data covering all continents. The 183 WHO member states were investigated. Statistical analysis was conducted from January to May 2024.Data represent 2 decades of longitudinal follow-up. Changes in life expectancy and health-adjusted life expectancy, as well as the healthspan-lifespan gap were quantified for all participating member states. Gap assessment was stratified by sex. Correlations of the gap with morbidity and mortality were examined. The healthspan-lifespan gap has widened globally over the last 2 decades among 183 WHO member states, extending to 9.6 years. A sex difference was observed with women presenting a mean (SD) healthspan-lifespan gap of 2.4 (0.5) years wider than men (P<.001). Healthspan-lifespan gaps were positively associated with the burden of noncommunicable diseases and total morbidity, and negatively with mortality. The US presented the largest healthspan-lifespan gap, amounting to 12.4 years, underpinned by a rise in noncommunicable diseases.This study identifies growing healthspan-lifespan gaps around the globe, threatening healthy longevity across worldwide populations. Women globally exhibited a larger healthspan-lifespan gap than men.

▶ Economic policy uncertainty, health status, and mortality

HUANG, W., LEI, X. ET YU, M.

2024

Social Science & Medicine 362: 117227

https://doi.org/10.1016/j.socscimed.2024.117227

Using data from 1985 to 2018 across up to 17 countries, this study shows that higher levels of economic policy uncertainty (EPU) are associated with reduced mortality rates and improved health outcomes, particularly among individuals aged 65 years and above. Notably, fatalities of most causes decrease with rising EPU, while suicide is an exception. Further investigation into potential explanations for the observed health improvement suggests that increased EPU is linked to individuals spending more time on self-care and leisure activities, adopting better health behaviors and reducing their labor supply. (JEL Classifications: E32, I10, I12, P36)

Géographie de la santé

Geography of Health

▶ « Santé, Vulnérabilité, Territoires », une chaire dans les Hauts-de-France

BOURDILLON, F.

2024

Sève : les tribunes de la santé (81): 83-92.

https://www.jle.com/10.1684/tsa.2024.35

En 2024, l'UFR 3S (Sciences, Sport et Santé), Sciences Po Lille et l'Agence régionale de santé Hauts-de-France ont créé une nouvelle chaire : la chaire « Santé, Vulnérabilité, Territoires » afin de concevoir, développer, implémenter des réponses innovantes aux enjeux de santé et en particulier concernant les inégalités sociales et territoriales de santé. Cette chaire a pour objectif de rassembler les mondes universitaires de l'expertise et de la recherche, de la gestion de la santé ainsi que celui des professionnels de santé. Les trois termes Santé, Vulnérabilité, Territoires symbolisent l'approche volontairement holistique de la chaire, de « pousser » la dimension pluridisciplinaire, notamment vers les sciences sociales et humaines et celle d'agir au plus près des lieux de vie (les territoires) et de prendre en compte les facteurs de vulnérabilité en santé. La conférence inaugurale de cette chaire a eu lieu le 14 octobre 2024. Ce texte en reprend les grandes lignes.

▶ Réussir la mise en place d'une démarche de consilience pour combattre les déserts médicaux

COURIE LEMEUR, A., GAUTIER, S., SZOSTAK, B. L., *et al.*

2024

Journal de gestion et d'Economie de la Santé 3(3): 89-110.

https://shs.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2024-3-page-89

Les déserts médicaux font partis des défis auxquels le système de santé français est aujourd'hui confronté. Si cette situation, source de tensions sociales et politiques, creuse les inégalités en matière de santé et alimente les débats sur l'équité, la justice sociale et le droit à la santé, elle apparait paradoxale tout particulièrement dans des territoires où il existe de nombreuses structures de formation des professionnels de santé, à commencer par les universités. C'est le cas dans le département des Yvelines en Ile-de-France. Dans cet article, nous questionnons le rôle de l'Université dans l'attractivité territoriale pour l'installation des professionnels de santé et nous cherchons à identifier des facteurs de réussite pour la mise en place d'une démarche de consilience au sein de l'Université, pour identifier des solutions innovantes aux déserts médicaux. Nous cherchons à comprendre Quels seraient les leviers de réussite pour la mise en place d'une démarche de consilience au sein de l'Université autour de la problématique des déserts médicaux ? Dans ce sens, nous menons une étude de cas exploratoire au sein de l'Université de Versailles Saint-Quentin-en-Yvelines en région parisienne, avec des équipes de recherche en management du laboratoire LAREQUOI et en santé publique de l'UFR Simone Veil-Santé et son département SPOT (Santé publique, prévention, observation, territoire), qui ont mené une réflexion conjointe pour trouver des solutions innovantes aux déserts médicaux sur le territoire des Yvelines. Nous décrivons ainsi le processus de mise en place d'une démarche de consilience autour de sujets complexes dans le champ de la santé.

▶ Housing for care, connection, and health equity

HOLTAN, M. T., BOWEN, E., MAISEL, J., *et al.*

2024

Health & Place 90: 103383.

https://doi.org/10.1016/j.healthplace.2024.103383

Researchers and policymakers have used a four-pillar framework— condition, consistency, context, and cost—to describe the characteristics of housing that are important for health equity. We propose adding a fifth pillar: care and connection. Housing for care and connection refers to the housing design, institutional policies, and housing programs that strengthen social connections, caregiving relationships, access to resources, and a sense of self in community. Attending to these needs in housing is especially important for people who are in transition in and out of homelessness, living in poverty, are very young or very old, or living with a disability or activity limitation.

▶ Analyse géographique et accès aux soins : la consommation de soins en fonction des diplômes

KANANOVICH, K., DE FONTGALLAND, C. ET MACE, J. M.

2024

Revue de droit sanitaire et social (Hors série): 27-37.

Cette étude propose d'explorer différentes mailles géographiques pour identifier une entité spatiale adéquate afin d'établir un diagnostic territorial concernant la consommation de soins de médecins généralistes en fonction du diplôme. Pour réaliser cette recherche, deux bases de données ont été mobilisées. D'abord, la base de recensement de la population de 2020, et ensuite, la base SNII-RAM issue du Système National des Données de Santé (SNDS).

▶ Does geographic availability of alcohol influence drinking in adolescents? A systematic review of literature associations

MARTIN-TURRERO, I., VALIENTE, R., PASTOR, A., *et al.*

2024

Health & Place 90: 103362.

https://doi.org/10.1016/j.healthplace.2024.103362

Background The role of alcohol geographic availability in influencing adolescent drinking has been debated. However, clear literature consensus has not been reached. Objective To provide a systematic review of the associations between geographic availability of alcohol outlets measured through different methodologies and drinking outcomes in adolescents. Methods We conducted a systematic search (PubMed/SCOPUS/Web of Science) for articles exploring associations between alcohol availability and adolescent drinking before 2023. Original articles written in English that evaluated adolescent populations (10–19 years old), included at least one quantitative alcohol consumption outcome and its relationship with geographic availability of alcohol, and declared no conflicts of interest were selected for the review. A quality assessment of the selected articles was made using the Newcastle-Ottawa Scale and descriptive analyses were carried out to summarize results. Results Thirty-one articles were reviewed (19 cross-sectional and 12 longitudinal studies), which included a total of 507336 participants. Alcohol availability was positively related to drinking prevalence and risky patterns in 53.3% and 60.5% of associations, respectively. Individual-level covariates, the type of alcohol outlets measured and the different methodological approaches to measure outlet density were related to differences in the direction and magnitude of these associations. Conclusion Just over half of the studies in this review demonstrate a positive association between alcohol availability and adolescent alcohol consumption with no negative associations reported. The review highlights the mix of methodological approaches that are used, which made it difficult to conduct joint analyses. Additional research is needed to explore the appropriateness, effectiveness and reliability of these methods within various contexts.

▶ Associations between the urban neighbourhood built and social environment characteristics with physical functioning among mid- and older-aged adults: A systematic review.

MOLAEI, P., ALIDADI, M., BADLAND, H., *et al.*

2024

Social Science & Medicine 362: 117412.

https://doi.org/10.1016/j.socscimed.2024.117412

There is growing recognition of the association between neighbourhood factors and individuals' health. This systematic review examines the associations between urban neighbourhood built and social environment characteristics with different measures of physical functioning among mid- and older-aged adults over 45 years, focusing on cross-sectional and longitudinal study designs. It responds to the increase in publications on this topic following the COVID-19 pandemic. The systematic review included 25 studies written in English from 2018 onwards sourced from 8 databases. Studies were imported into Covidence and reviewed following the 'Preferred Reporting Items for Systematic Reviews and Meta-Analysis' (PRISMA) protocols. Findings were assessed according to 13 neighbourhood environment variables: aesthetics, crime safety, greenness and parks, land use mix and destinations, neighbourhood disadvantage, pedestrian/street infrastructure, public transport, residential density, social environment, street connectivity, traffic safety, walkability, and composite variables. Significant associations in the expected direction were found for land use mix and destinations, walkability, crime safety, greenness and parks, social environment, and neighbourhood disadvantage with physical functioning in mid- and older-aged adults. Weaker evidence of expected associations was found for residential density and aesthetics. Future research avenues on this topic include investigating built and social neighbourhood environments in diverse geographies and populations, considering housing status and length of exposure to the neighbourhood environment, using longitudinal surveys over longer time periods and objective measurements.

▶ Spatial patterns of rural opioid-related hospital emergency department visits: A machine learning analysis

ROBINSON, E., STEWART, K., ARTIGIANI, E., *et al.*

2024

Health & Place 90: 103365.

https://doi.org/10.1016/j.healthplace.2024.103365

As opioid-related overdose emergency department visits continue to rise in the United States, there is a need to understand the location and magnitude of the crisis, especially in at-risk rural areas. We analyzed sets of ZIP code level electronic health records for emergency department visits from 6 hospitals for two rural regions of Maryland with higher opioid-related overdose rates. Analysis of the demographics of visits found Black or African American emergency department visits in both rural regions were higher than the proportion of their population per region. We trained random forest models with socio-demographic factors and health risk factors on the visits data to understand drivers and risk factors for opioid misuse. The models ranked factors relating to opioid prescribing rates, race, housing, and poor mental health as highly important. Factors associated with opioid-related overdose emergency department visits were found to vary by race, gender, and location and may provide useful insights for designing mitigation initiatives.

▶ Moderators and mediators of the association between the obesogenicity of neighbourhoods and weight status in Dutch adults

VAN DE GEEST, J. D. S., MEIJER, P., REMMELZWAAL, S., *et al.*

2024

Health & Place 90: 103364.
https://doi.org/10.1016/j.healthplace.2024.103364

This study aimed to assess sociodemographic, personality, and psychological moderators, and lifestyle behavioural mediators, of the association between obesogenicity of neighbourhoods and weight status in Dutch adults. This cross-sectional study used baseline data of 150,506 adult participants of the Lifelines study. To quantify obesogenicity of Dutch neighbourhoods, the Obesogenic Built Environment CharacterisTics (OBCT) index was used, calculated for 1000 m circular buffers around participant's residencies. Z-scores of components across food and physical activity (PA) environments were averaged, and rescaled from 0 to 100. Weight status was operationalised as objectively measured waist circumference. Stratified linear regression analyses by (self-reported) sociodemographic factors, perceived stress, impulsivity, self-discipline, and deliberation were conducted when interaction terms were significant ($P < .01$). Mediation by adherence to the Dutch PA guidelines and dietary behaviour was examined using the difference-in-coefficients approach. Every 10% increase in OBCT index was associated with a 0.65 ($P < .001$, 95%CI [0.59, 0.71]) centimetre larger waist circumference. The association was largest for respondents who were younger, had the lowest income, the highest educational level, the least self-discipline, the highest impulsivity scores and the most perceived stress. Adherence to PA guidelines and dietary behaviour mediated 13.3% of this association; however, the difference in coefficients was not statistically significant. Our findings enable to better target lifestyle interventions to individuals most vulnerable to obesogenic environments. Furthermore, they provide guidance for policymakers and urban planners in promoting health-enhancing environments.

Differences in the influence of the built environment on physical activities for people with normal weight, overweight, and obesity

ZOU, Y. ET WANG, D.

2024

Health & Place 90: 103385.
https://doi.org/10.1016/j.healthplace.2024.103385

The link between the built environment and physical activity (PA) has received substantial research attention in health geography and public health studies. Limited research efforts have been spent to investigate if the link would be different for people with or without obesity, and prior studies often overlook potential nonlinear associations. Knowledge of such potential differences will be essential for developing tailor-made urban planning or spatial policies to promote physical activities and health for different population groups. This study aims to address this research gap by exploring the nonlinear relationships between the built environment and PA engagement for people with normal weight, overweight, and obesity. Data are derived from a two-day household activity-travel diary survey conducted in 2018 in Shanghai, China. Using gradient boosting decision tree models, this study found distinct influences of the built environment on total PA duration and active PA for different weight status groups. Residents with obesity tend to have a shorter total PA duration and a lower rate of participating in active PA. By comparing the model results, it shows that the impact of the built environment on active PA is larger than that on the total PA duration for all three weight groups, and this increase is more pronounced for the obesity group. Population density, public transit, and land use mix are the three key built environment variables that exert nonlinear effects on PA engagement across all weight groups, with variations in trend and threshold values between groups. This research presents new insights into the relationship between the built environment and physical activities, which are relevant for promoting physical activities among people with different weight statuses.

Handicap

Disability

Les pratiques de coordination du proche aidant dans le cadre du parcours de santé de la personne en situation de handicap : une étude exploratoire

ROURE, E. ET TOSI, L.

2024

Journal de gestion et d'économie de la santé 41(2): 24-40.

https://shs.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2024-2-page-24

En France, on estime à plus de 9 millions le nombre de proches aidant apportant une aide régulière à un proche en situation de handicap. Bien que considéré comme indispensable à la coordination du parcours de santé, peu d'études s'intéressent aux pratiques de coordination développées par le proche aidant. Cette étude exploratoire cherche à enrichir la littérature en identifiant les pratiques de coordination du proche aidant dans le cadre du parcours de santé de la personne en situation de handicap. Les premiers résultats obtenus permettent d'identifier et de détailler les composantes des pratiques de coordination préalablement identifiées au sein de la littérature : les pratiques de supervision, de communication et de médiation. La recherche soulève également l'émergence des pratiques de coordination réflexives. Nos résultats de terrain soulignent ainsi l'importance des pratiques de coordination développées par le proche aidant dans le cadre du parcours de santé de la personne en situation de handicap.

Potentially avoidable mortality among adults with intellectual disability

THYGESEN, L. C., KLITGAARD, M. B., SABERS, A., *et al.*

2024

European Journal of Public Health 34(6): 1225-1231.

https://doi.org/10.1093/eurpub/ckae118

Persons with intellectual disabilities (ID) face pronounced health disparities. The aim of this study was to describe premature mortality by causes of death and avoidable mortality among persons with ID compared to the general Danish population. This study is based on a Danish nationwide cohort of adults (aged 18–74 years) with ID (n = 57 663) and an age- and sex-matched reference cohort (n = 607 097) which was established by linkage between several registers. The cohorts were followed in the Register of Causes of Death between 2000 and 2020. Causes of death were categorized into preventable, treatable, or unavoidable deaths using the OECD/Eurostat classification and furthermore categorized into specific interventions. We compared the observed and expected number of deaths by calculating standardized mortality ratio (SMR). Among persons with ID the number of deaths was 9400 whereof 5437 (58%) were avoidable. SMR for preventable deaths, e.g. by reducing smoking and alcohol intake or by vaccination, was 2.62 (95% CI, 2.51–2.73), and SMR for treatable deaths, e.g. by earlier diagnosis and treatment, was 6.00 (5.72–6.29). Unavoidable mortality was also six-fold increased (SMR = 6.03; 5.84–6.22). Preventable deaths were higher for persons with mild ID compared to severe ID, while treatable and unavoidable mortality were highest for persons with severe ID. The study confirmed that persons with ID have an amplified risk of mortality across all categories. There is a need for competence development of social care and healthcare personnel and reasonable adjustment of health promotion programs and healthcare services for people with ID.

Hôpital

Hospital

Variation in day surgery Rates across Irish Public Hospitals

BRICK, A., WALSH, B., KAKOULIDOU, T., *et al.*

2024

Health Policy 152 :105215.

https://doi.org/10.1016/j.healthpol.2024.105215

The appropriate use of day surgery has been shown to provide the same or better outcomes for patients and to increase hospital efficiency. However, it is often underutilised, and rates can vary widely across hospitals. This study examines variation in day-surgery rates across Irish public hospitals and identifies the characteristics associated with these variations. Using patient-level administrative data on high-volume elective procedures, three-level logistic regression models are estimated which allow us to attribute variation in day-surgery rates to hospitals and surgical-teams. We find that day-surgery rates have increased in the last decade and vary substantially between hospitals for most procedures examined. Focusing on laparoscopic cholecystectomy, a key procedure targeted by policymakers, rates varied from 0% to over 90% across hospitals in 2019. We find that a substantial amount of variation in likelihood of day surgery is attributable to the surgical team (56.8%) with 37.8% attributable to the hospital. While there has undoubtedly been progress in the use of day surgery in Ireland there is still scope for improvement. A policy focus on encouraging and incentivising surgical team adoption of day surgery may be warranted, in addition to dedicated resources, and monitoring of day-surgery rate variation across hospitals.

Could hospitals operating through a value-based healthcare policy overcome potential management drawbacks in European healthcare?

CARAMÉS, C., ARCOS, J., PFANG, B., *et al.*

2025

Policy Comment. Health Policy 152: 105249.

https://doi.org/10.1016/j.healthpol.2025.105249

La situation économique des établissements de santé

CASH, R.

2024

Sève : les tribunes de la santé (81): 63-76.

https://shs.cairn.info/revue-les-tribunes-de-la-sante-2024-3-page-63

Les établissements de santé, publics et privés, après la sortie de la crise sanitaire, connaissent une crise des ressources humaines, qui constitue l'un des principaux facteurs de la faiblesse de la reprise d'activité. Sur l'ensemble de la période 2020-2023, 3,1 millions de séjours ont été « perdus » malgré une forte reprise de l'activité en 2023. Les hôpitaux publics ont perdu des parts de marché dans certaines spécialités par rapport aux cliniques. Et la sanction budgétaire est forte : 1,3 milliard d'euros de déficit pour le secteur public, un montant jamais atteint jusqu'à présent. Les cliniques privées sont dans une situation plus favorable, avec un résultat net positif de 627 millions. Mais dans les deux secteurs, on trouve un taux élevé d'établissements surendettés, respectivement 34 % et 18 %. La diminution des investissements dans les hôpitaux publics a conduit à un plan d'envergure, dans le cadre du Ségur de la santé, pour restaurer les capacités financières des établissements. Mais sans changement majeur de la politique de l'offre de soins et de gestion de l'Ondam, les déficits hospitaliers resteront élevés.

Médecin ET gestionnaire : Une étude de portée !

CÔTÉ, A., BENHARBIT, B., LEMAIRE, C., *et al.*

2024

Journal de gestion et d'économie de la santé 3(3): 6-38.

https://shs.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2024-3-page-6

Le bon fonctionnement des activités cliniques dans les établissements de santé requiert l'implication des médecins dans la gestion. Toutefois, ceux-ci se montrent peu enclins à s'impliquer dans un rôle managérial. Il apparait ainsi essentiel de mieux comprendre le rôle de médecin-gestionnaire et d'investiguer les différents facteurs susceptibles d'influencer leur implication afin de mieux les accompagner dans la gestion des activités cliniques. Cette étude de portée inclut 26 études sélectionnées en suivant les lignes directrices PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) et a permis d'identifier les facteurs facilitants/inhibants l'implication des médecins dans la gestion, les attentes de la part des médecins et de leurs collaborateurs, les besoins des médecins et des pistes d'amélioration permettant de favoriser leur implication dans la gestion. Les résultats révèlent les facteurs déterminant la motivation des médecins à s'engager dans un rôle managérial, l'influence du contexte et du soutien organisationnels, ainsi que des pistes d'amélioration du processus. Ces résultats présentent un intérêt tant pour les politiques de gestion des carrières au sein des organisations de santé que pour la formation universitaire des médecins.

▶ Effects of rural hospital closures on nurse staffing levels and health care utilization at nearby hospitals

DONG, J., LIU, S., COVELLI, A. F., *et al.*

2024

Health Economics 33(12): 2687-2707.

https://doi.org/10.1002/hec.4889

Abstract Our study examines the causal effect of rural hospital closures on nearby hospitals' nurse staffing levels and health care utilization. We use data from the 2014–2019 American Hospital Association Survey on nurse staffing level outcomes including licensed practical or vocational nurses (LPNs), registered nurses (RNs), and advanced practice nurses (APNs); and health care utilization outcomes, including inpatient and outpatient surgical operations and emergency department (ED) visits. Using propensity score matching and difference-in-differences (DID) methods, we find that rural hospital closures lead to an average increase of 37.3% in the number of nurses in nearby rural hospitals during the 4 years following the closure. This increase is found across all categories of nurses, including LPNs, RNs, and APNs. We also find a substantial increase in the provision of inpatient and outpatient surgical operations but there is no change in ED visits. We do not find any effects for nearby urban hospitals. Our study suggests that a large proportion of the nursing workforce relocates to nearby hospitals after a rural hospital closure, which mitigates the negative consequences of such closures and allows these nearby hospitals to provide a larger volume of highly profitable services.

▶ Impact of multicomponent intervention on hospitalized clinical patient outcomes: A pre–post study in a university hospital

FALCETTA, M. R. R., PIVATTO JÚNIOR, F., CASSOL, É. P., *et al.*

2024

Journal of Healthcare Quality Research 39(6): 365-372.

https://doi.org/10.1016/j.jhqr.2024.06.003

Background and objective Hospitalization significantly interferes with the individual's well-being and it occurs both during and after the hospitalization period. Different approaches to minimize morbidity related to hospitalization and the post-discharge period have been proposed, especially to those aimed at reducing readmission rates. The aim of this study is to evaluate the effect of multicomponent intervention (MI) on operational indicators and continuity of care outcomes. Materials and methods A quasi-experimental study conducted in a Brazilian university hospital in order to compare the impact of the intervention with usual care. The MI was the implementation of multidisciplinary rounds, the inclusion of the role of the navigator nurse, and care transition actions with half of the Internal Medicine teams in a clinical unit of a general hospital. Adult patients hospitalized were included in 2 periods and divided in 3 groups – Group A: before the intervention; Group B: after and with MI; Group C after and without MI. Results A total of 2333 hospitalizations were evaluated. There was a reduction in the rate of intensive care transfers to intensive care unit (ICU) and in the length of stay (LOS). LOS, discharge before noon, and transfers to ICU improved when comparing before and after the intervention, but were not different in post-intervention groups with and without MI. Conclusion These results reflect the improvement of care provided by MI, an effect that could be due to cross contamination also to teams without the intervention.

▶ Triage at shift changes and distortions in the perception and treatment of emergency patients

FERRO, S. ET SERRA, C.

2025

J Health Econ 99: 102944.

https://doi.org/10.1016/j.jhealeco.2024.102944

Employing more than 2 million emergency department (ED) records, we combine machine learning and regression discontinuity to document novel distortions in triage nurses' assessments of patients' conditions and investigate the short- and medium-term consequences for patients. We show that triage nurses progressively become more lenient during their shifts, and identical ED patients arriving just after a shift change are thus assigned a lower priority. We show that these patients receive lower levels of care and require additional emergency care afterward. We conclude that distortions in nurses' initial assessments of urgency bias' medical staff's perceptions.

Evolving Dynamics of Relational Coordination: A Study of Progression of Care Huddles in Hospital Observation Services

GOMES, P. J. ET MIRZAEI, T.

2025

Med Care Res Rev 82(1): 88-99.

https://doi.org/10.1177/10775587241284328

Health care organizations are increasingly using team huddles to enhance communication, improve patient experience, and deliver timely care. However, established practices, resource constraints, and hierarchical role dynamics can hinder the effectiveness of huddling. This study investigates the dynamics of care huddle implementation through interviews with care providers and managers of an observation unit in a U.S. hospital. Qualitative analysis of interview data reveals that huddle adoption enhances relational coordination (RC), thus highlighting the importance of both coaching interventions in fostering proactive behavior and the building of a work environment aligned toward shared goals. The findings affirm RC as a dynamic change model, examining its interplay with organizational processes and structure. The study underscores the significance of adaptations in work processes, the role of informal boundary spanners in facilitating cross-departmental coordination, and structural changes that increase autonomy for low-power actors. We offer actionable recommendations for health care organizations aiming to improve care coordination.

Cost, Quality, and Utilization After Hospital-Physician and Hospital-Post Acute Care Vertical Integration: A Systematic Review

HARRIS, A., PHILBIN, S., POST, B., *et al.*

2025

Medical Care Research and Review 82(1): 3-42.

https://doi.org/10.1177/10775587241247682

Vertical integration of health systems—the common ownership of different aspects of the health care system—continues to occur at increasing rates in the United States. This systematic review synthesizes recent evidence examining the association between two types of vertical integration—hospital-physician (n = 43 studies) and hospital-post-acute care (PAC; n = 10 studies)—and cost, quality, and health services utilization. Hospital-physician integration is associated with higher health care costs, but the effect on quality and health services utilization remains unclear. The effect of hospital-PAC integration on these three outcomes is ambiguous, particularly when focusing on hospital-SNF integration. These findings should raise some concern among policymakers about the trajectory of affordable, high-quality health care in the presence of increasing hospital-physician vertical integration but perhaps not hospital-PAC integration.

Les usages des outils de gestion des effectifs par les cadres de santé : le cas de l'hôpital public

JACOB, M. A.

2024

Journal de gestion et d'économie de la santé 41(2): 5-23.

https://shs.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2024-2-page-5

Pour répondre aux attentes de plus en plus fortes et variées qui pèsent sur le secteur de la santé (amélioration de la qualité des soins, maitrise de la masse salariale…), les outils de gestion foisonnent à l'hôpital. Parmi les acteurs utilisant ces outils, les cadres de santé ont un rôle pivot consistant à intégrer et à faciliter la coopération autour des enjeux de gestion des ressources humaines dans une organisation relevant de groupes professionnels différenciés. Cette recherche a pour objectif de comprendre comment les cadres de santé utilisent les outils de gestion des effectifs à l'hôpital public. Pour cela, une étude de cas a été menée dans un CHU français : 42 entretiens semi-directifs, 16 demi-journées d'observation et des données secondaires ont été collectés. Nous montrons que les outils de gestion peuvent être utilisés de six manières différentes : trois usages instrumentaux, mis en œuvre entre cadres ou en lien avec l'équipe paramédicale et trois usages sociopolitiques, déployés au contact des différents groupes professionnels de l'hôpital. Nous contribuons à rapprocher les littératures en comptabilité/ contrôle de gestion et en gestion des ressources humaines en montrant que les outils de gestion constituent une ressource dont les cadres peuvent se saisir activement pour contribuer à incarner leur rôle pivot au carrefour des différents mondes de l'hôpital.

▸ Variation in attendance at emergency departments in England across local areas: A system under unequal pressure

JACOB, N., CHALKLEY, M., SANTOS, R., *et al.*

2024

Health Policy 150: 105186.

https://doi.org/10.1016/j.healthpol.2024.105186

Background Crowding in Accident and Emergency Departments (AEDs) and long waiting times are critical issues contributing to adverse patient outcomes and system inefficiencies. These challenges are exacerbated by varying levels of AED attendance across different local areas, which may reflect underlying disparities in primary care provision and population characteristics. Method We used regression analysis to determine how much variation across local areas in England of attendance at emergency departments remained after controlling for population risk factors and alternative urgent care provision. Findings There is substantial residual variation of the order of 3 to 1 (highest to lowest) in per person attendance rate across different areas. This is not related to in-hospital capacity as proxied by the per person number of hospital emergency doctors in an area. Conclusion Some areas in England have emergency departments that are under much greater pressure than others, and this cannot be explained in terms of their population characteristics or the availability of alternative treatment options. It is imperative to better understand the drivers of this variation so that effective interventions to address utilisation can be designed.

▸ Assessing the quality of public services: For-profits, chains, and concentration in the hospital market

KUNZ, J. S., PROPPER, C., STAUB, K. E., *et al.*

2024

Health Economics 33(9): 2162-2181.

https://doi.org/10.1002/hec.4861

Abstract We examine variation in US hospital quality across ownership, chain membership, and market concentration. We propose a new measure of quality derived from penalties imposed on hospitals under the flagship Hospital Readmissions Reduction Program, and use regression models to risk-adjust for hospital characteristics and county demographics. While the overall association between for-profit ownership and quality is negative, there is evidence of substantial heterogeneity. The quality of for-profit relative to non-profit hospitals declines with increasing market concentration. Moreover, the quality gap is primarily driven by for-profit chains. While the competition result mirrors earlier findings in the literature, the chain result appears to be new: it suggests that any potential quality gains afforded by chains are mostly realized by not-for-profit hospitals.

▸ Processing and validation of inpatient Medicare Advantage data for use in hospital outcome measures

KYANKO, K. A., SAHAY, K. M., WANG, Y., *et al.*

2024

Health Serv Res 59(6): e14350.

https://doi.org/10.1111/1475-6773.14350

OBJECTIVE: To determine the feasibility of integrating Medicare Advantage (MA) admissions into the Centers for Medicare & Medicaid Services (CMS) hospital outcome measures through combining Medicare Advantage Organization (MAO) encounter- and hospital-submitted inpatient claims. DATA SOURCES AND STUDY SETTING: Beneficiary enrollment data and inpatient claims from the Integrated Data Repository for 2018 Medicare discharges. STUDY DESIGN: We examined timeliness of MA claims, compared diagnosis and procedure codes for admissions with claims submitted both by the hospital and the MAO (overlapping claims), and compared demographic characteristics and principal diagnosis codes for admissions with overlapping claims versus admissions with a single claim. DATA COLLECTION/EXTRACTION METHODS: We combined hospital- and MAO-submitted claims to capture MA admissions from all hospitals and identified overlapping claims. For admissions with only an MAO-submitted claim, we used provider history data to match the National Provider Identifier on the claim to the CMS Certification Number used for reporting purposes in CMS outcome measures. PRINCIPAL FINDINGS: After removing void and duplicate claims, identifying overlapped claims between the hospital- and MAO-submitted datasets, restricting claims to acute care and critical access hospitals, and bundling same admission claims, we identified 5,078,611 MA admissions. Of these, 76.1% were submitted by both the hospital and MAO, 14.2% were submitted only by MAOs, and 9.7% were submitted only by hospitals. Nearly all (96.6%) hospital-submitted claims were submitted within 3 months after a one-year performance period, versus 85.2% of MAO-submitted claims. Among the 3,864,524 admissions with overlapping claims, 98.9% shared the same principal diagnosis code between the two datasets, and 97.5% shared the same first procedure code. CONCLUSIONS: Inpatient MA data are feasible for use in CMS claims-based hospital outcome measures. We recommend prioritizing hospital-submitted over MAO-submitted claims for analyses. Monitoring, data audits, and ongoing policies to improve the quality of MA data are important approaches to address potential missing data and errors.

Impact of hospital-physician vertical integration on physician-administered drug spending and utilization

LEVIN, J. S., ZHAO, X. ET WHALEY, C.

2025

Health Economics 34(2): 345-367.

https://doi.org/10.1002/hec.4909

Abstract We estimate the effects of hospital-physician vertical integration on spending and utilization of physician-administered drugs for hematology-oncology, ophthalmology, and rheumatology. Using a 100% sample of Medicare fee-for-service medical claims from 2013 to 2017, we find that vertical integration shifts treatments away from physician offices and toward hospital outpatient departments. These shifts are accompanied by increases in physician-administered drug administration spending per procedure for all three specialties. Spending on Part B drugs also increases for hematologist-oncologists. At the same time, physician treatment intensity, as measured by the number of beneficiaries who receive drug infusions/injections and the number of drug infusions, decreases across all three specialties. These results suggest that the incentives of the Medicare reimbursement system, particularly site-of-care payment differentials and outpatient drug reimbursement rates, interact with vertical integration to lead to higher overall spending. Policies and merger guidelines should attempt to restrain spending increases attributed to vertical integration.

Partir ou rester ? Les médecins hospitaliers à l'épreuve des réformes de santé

MALTIS, A. L., CORNET, C., BALIZET, D., *et al.*

2024

Santé Publique 36(6): 65-73.

https://stm.cairn.info/revue-sante-publique-2024-6-page-65

Introduction : Dans un contexte de crise au sein de l'hôpital public, la question du désengagement des professionnels de santé est primordiale. Le nombre croissant de démissions, largement médiatisé pour les infirmières et les aides-soignantes, se propage également au sein de la profession de médecin. But de l'étude : L'Espace de réflexion éthique Bourgogne – Franche-Comté a choisi d'investiguer les raisons du vacillement de l'engagement des médecins exerçant au sein de l'hôpital public au travers d'une étude qualitative. Résultats : Coupes budgétaires, manque d'effectifs, manque de lits, devoir de rentabilité… seraient à l'origine du surinvestissement des professionnels de santé et participeraient de manière plus globale au désengagement des médecins envers le service public hospitalier. Conclusions : Les contraintes énumérées par les médecins hospitaliers pointent du doigt les politiques managériales actuelles du système de santé public. Ces différentes critiques des outils mis en place dans la gestion et le mode de financement des hôpitaux mettent en lumière les conflits macro et microsociaux du système public hospitalier menaçant sa pérennité.

Which factors influence the decision of hospitals to provide procedures on an outpatient basis? Mixed-methods evidence from Germany

MESSERLE, R., HOOGESTRAAT, F. ET WILD, E. M.

2024

Health Policy 150: 105193.

https://doi.org/10.1016/j.healthpol.2024.105193

Shifting care from the resource-intensive inpatient setting to the more economically efficient outpatient sector is being promoted internationally by policymakers. Financial incentives are a major focus of such efforts because low levels of hospital outpatient care are attributed to differences in payment for inpatient and outpatient services. In Germany, however, there is significant variation in the extent to which hospitals provide outpatient care despite a uniform payment system. Therefore, other factors must be influencing

German hospitals' strategic decisions whether to offer outpatient care. While most research has focused on specific procedures or lacks empirical support, our study provides a comprehensive analysis of the factors beyond financial incentives that influence the provision of hospital outpatient services in Germany. We employed a mixed-methods approach, first contacting health care experts with in-depth knowledge of the hospital outpatient landscape to identify possible influencing factors and then conducting a comprehensive quantitative analysis of all German hospitals. Our findings suggest that policymakers seeking to promote hospital outpatient care should consider a broad range of factors. We found that a hospital's service mix, size, procedure volume, and emergency care infrastructure significantly affected the proportion of outpatient services it offered. Strategic hospital planning emphasizing specialization and adherence to minimum volume standards might therefore be a valuable policy tool. Our analysis also highlights the importance of demographic and socioeconomic factors, such as the regional share of single-person households, suggesting that a comprehensive policy framework should account for broader population characteristics and not just elements directly related to hospital care.

▶ Determinants of citizens' choice between public and private hospitals

PARRADO, S., RAMA, J. ET REYNAERS, A. M.

2024

Journal of Healthcare Quality Research 39(6): 391-398.

https://doi.org/10.1016/j.jhqr.2024.09.001

Objective This study assesses what factors determine citizens' preferences for a public or private hospital (assuming the choice is free of charge) according to the severity of the disease. Material and method A web-based discrete choice experiment was carried out with 1777 individuals distinguishing between a control group (posed with a simple choice for each health condition) and added information for respondents of the treatment groups (distance, waiting time, advice from the family doctor, and recommendations from the social context). The relevance of these factors in relation to the severity of one's illness is investigated. The outcome variable is the choice of a public versus a private hospital for the treatment of a health issue of a different severity. Results The severity of the health issue has a moderator effect on the additional information for the treatment groups. Waiting time has a direct positive impact on the patient's preferred choice for a private hospital both for severe and non-severe health issues. Distance to the hospital and the family doctor's recommendation positively impact the preferred choice for a private hospital for non-severe health issues but not for severe health issues. Covariates like gender and age are not relevant in explaining the effects of the treatments, and educational level has a positive impact on one of the treatments: advice from the patient's environment. Satisfaction with public hospitals has a positive impact on all treatments. Conclusions Results indicate that waiting time is a key factor in choosing a private hospital against the majority-stated preference for a public hospital.

▶ Hospitals' collection and use of data to address social needs and social determinants of health

RICHWINE, C. ET MEKLIR, S.

2024

Health Services Research 59(6): e14341.

https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.14341

Abstract Objective To assess differences in hospitals' collection and use of data on patients' health-related social needs (HRSN) by availability of programs or strategies in place to address patients' HRSN and social determinants of health (SDOH) of communities. Data Sources The 2021 American Hospital Association Annual Survey and 2022 Information Technology (IT) Supplement. Study Design This cross-sectional study described hospitals' engagement in screening and the availability of programs or strategies to address nine different HRSN. We assessed differences in screening rates and uses of data collected through screening among hospitals with and without programs or strategies in place to address HRSN or SDOH using Chi-squared tests of independence. Data Collection/Extraction Methods Analyses were restricted to IT Supplement respondents with complete data for social needs questions asked in the Annual Survey (N = 1997). Principal Findings In 2022, hospitals used social needs data collected through screening for various purposes including discharge planning and clinical decision-making at their hospital as well as to refer patients to needed resources and assess community-level needs. Hospitals with a program or strategy in place had higher rates of screening across all domains and higher rates of using of data collected through screening for uses involving exchange or coordination with external entities. Conclusions Collection of social needs data may help inform the development of programs or strategies to address HRSN and SDOH, which in turn can enable providers to screen for these needs and use the data in the near term for care delivery and in the long term to address community and population needs.

Médecin-manager : une hybridation institutionnelle ? Étude de la fonction managériale des médecins managers d'un CHU : vers une hybridation des logiques institutionnelles ?

SIBÉ, M., GAGNOU-SAVATIER, E. ET AZAGHOUAGH-EL FARDI, W.

2024

Journal de gestion et d'économie de la santé 41(2): 41-59.

https://shs.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2024-2-page-41

Les hôpitaux publics français traversent une crise manifeste de la gestion de leurs ressources humaines. La transformation de la gouvernance hospitalière et l'évolution réglementaire qui l'accompagne interrogent les conditions d'exercice de la responsabilité de médecin-chef de service et le périmètre de leur fonction. Dans un contexte hospitalier public français qui souhaite affirmer la volonté de ré-instituer les médecins-chefs de service comme des acteurs managériaux de premier plan, il paraît pertinent de comprendre leur rôle et la manière dont ils parviennent à conjuguer les logiques médicales et gestionnaires. A partir du cadre théorique néo-institutionnel (DiMaggio et Powell, 1983 ; Meyer et Rowan, 1977), nous mobilisons le concept de logique institutionnelle des acteurs afin de nous intéresser à la manière dont des « acteurs hybrides » – médecins-managers – situés à l'interface de différentes logiques, parviennent à concilier ces logiques complémentaires ou contradictoires. Les résultats de cette recherche menée à partir de 14 entretiens semi-structurés avec des chefs de services (CS) ou responsables d'unités (RU) montrent un intérêt mitigé pour l'accès à la fonction managériale, la réalisation par les médecins-managers de nombreuses missions en lien avec la logique gestionnaire, le maintien d'une logique médicale et une hybridation des logiques qui se révèle être complexe.

Inégalités de santé

Health inequalities

Parcours de sans-abrisme de femmes en migration : pour une définition de l'abri et du sans-abrisme attentive aux enjeux de genre

ARNAUD, C.

2024

Revue française des affaires sociales 243(3): 277-295.

https://shs.cairn.info/revue-francaise-des-affaires-sociales-2024-3-page-277

S'appuyant sur une recherche doctorale auprès de femmes sans-abri en migration, cet article réinterroge la définition du sans-abrisme en menant une réflexion autour de la notion d'abri soucieuse des enjeux de genre. L'analyse du parcours des femmes rencontrées montre que l'accès à un hébergement ou un logement ne suffit pas à constituer un abri. Si l'accès à un espace privé est fondamental, il leur est nécessaire de ne pas y être enfermées ni cantonnées. Ce constat amène à ne plus considérer l'abri comme un espace privatisé minimal, mais à le définir comme une caractéristique (ou pas) de l'espace habité, indexée sur son ouverture à l'espace public.

[Expérience] Soutenir la santé mentale des personnes migrantes ou désanitariser le soin ?

AUVIGNE, C., CHAMBON, N. ET REMY, V.

2024

Revue française des affaires sociales 243(3): 215-234.

https://shs.cairn.info/revue-francaise-des-affaires-sociales-2024-3-page-215

Inégalités sociales de santé et confinement : quels effets des conditions sociales d'existence sur le vécu des personnes atteintes par la mucoviscidose en France pendant la pandémie de Covid-19 ?

BÉGOT, A. C. ET POMBET, T.

2024

Revue française des affaires sociales 244(4): 192-213.

https://shs.cairn.info/revue-francaise-des-affaires-sociales-2024-4-page-192

La pandémie de Covid-19 et les mesures de confinement associées ont fortement impacté la gestion institutionnelle des maladies chroniques sur le plan international. Dans le contexte français, cet article interroge l'effet différencié de la situation sanitaire selon les conditions sociales d'existence des personnes atteintes par la mucoviscidose. Notre analyse s'appuie sur le volet qualitatif d'une recherche à dimension nationale, comprenant la conduite de 28 entretiens approfondis, conduits de manière longitudinale avec 15 personnes aux profils sociaux diversifiés (âge, sexe, classe sociale) pour interroger leur expérience de la maladie et des soins pendant cette période. Les résultats montrent que les caractéristiques propres aux classes sociales ou à certaines assignations sociales (de sexe et d'âge) peuvent conduire à l'adoption de comportements différenciés et à des vécus différents sur trois domaines – l'accès à l'information sur le Covid-19, les expériences de sociabilité et la pratique d'activités physiques et sportives – ouvrant à la production, au renforcement ou à la persistance d'inégalités sociales de santé.

Pathways from education to mortality, mediated through income

BIJWAARD, G. E. ET BARCLAY, K. J.

2025

Health Economics 34(1): 18-44.

https://doi.org/10.1002/hec.4894

Abstract Lower levels of education are associated with higher mortality. Lower levels of education are also associated with lower income, which is also associated with higher mortality. We investigate the impact of education on mortality and the extent to which this is mediated through income over the life course. We account for both selective educational attainment and selective income over the life course, through inverse propensity weighting (IPW) of the mortality hazard. We decompose the educational gain, that is, the decrease in mortality from more education, in the hazard into an indirect effect of education, running through changes in income and a direct effect of education, running through other factors. We use Swedish conscription data (men only), linked to parental information and individual annual income for the period 1968 till 2012. Our empirical results indicate large educational gains in mortality. We also find that this educational gradient runs through changes in income, especially for the more educated, and does not run through other factors related to education. We conduct several robustness and sensitivity checks that indicate that the results are robust.

Grande précarité en France : analyse de la persistance du cloisonnement des secteurs social, médical... et psychologique

CHEVREAU, G., DUPUIS, M., CASTILLO, M. C., *et al.*

2024

Santé Publique 36(6): 39-42.

https://stm.cairn.info/revue-sante-publique-2024-6-page-39

Dans cet argumentaire, nous nous interrogeons sur les raisons pour lesquelles les psychologues sont peu présents sur le terrain de la grande précarité en France, alors que les besoins en santé mentale y sont relativement bien décrits. Pour répondre à cette question, nous discutons la manière dont les sciences sociales ont permis des avancées dans l'accompagnement des personnes Sans Domicile, alors qu'historiquement, les sciences psychologiques se sont peu penchées sur cette population. Nous évoquons également le cloisonnement des secteurs médical et social, qui rend les soins en santé mentale plus difficiles d'accès et limite les interventions psychologiques. Nous concluons cet article en soulignant certaines avancées récentes sur cette question et encourageons les dispositifs à tendre vers une compréhension médico-psycho-sociale de la grande précarité.

Migrations et santé : faire face au soin entravé contraintes, expériences, adaptations. Avant-propos

D'HALLUIN, E., TISSERAND, C. ET WANG, S.

2024

Revue française des affaires sociales 243(3): 7-24.

https://shs.cairn.info/revue-francaise-des-affaires-sociales-2024-3-page-7

The double disadvantage faced by adolescents from low socioeconomic backgrounds with mental health problems affects earnings up to mid-life

EVANS-LACKO, S., FONT GILABERT, P. ET KNAPP, M.

2024

Social Science & Medicine 362: 117385.

https://doi.org/10.1016/j.socscimed.2024.117385

Early childhood socioeconomic disadvantage and mental health problems are both important determinants of adult social and economic experiences, but little is known about how they interact in this respect. We aimed to assess whether poor mental health in adolescence exacerbates labour market inequalities originating from low socioeconomic status (SES) in childhood. We use a birth cohort of individuals born in 1958 in England and follow their employment experiences and cumulative earnings up to age 55. We proxy low SES in childhood with father's occupational class at the time the respondent was aged 11, and use caregiver (usually, parent) ratings of the Rutter inventory at age 16 to identify mental health problems in adolescence. We fit ordinary least squares (OLS) models to estimate the effect of growing up in a low-SES family and experiencing mental health problems (conduct or emotional problems) in adolescence on cumulative earnings (log-transformed). We use an interaction term to test whether the association between mental health problems (conduct and emotional separately) and earnings differed by socioeconomic group. Individuals who experienced conduct problems in adolescence had lower cumulative earnings and employment levels up to age of 55. Moreover, the association between mental health problems and cumulative earnings was higher among individuals who also experienced low SES in childhood. Families from a higher socioeconomic group may have more effective means to counteract the adverse impacts of adolescent mental health problems, likely due to broader access to resources, support systems and opportunities. This underscores the role of structural supports in addressing socioeconomic inequalities in mental health outcomes and their long-terms implications.

Une santé à la marge : l'imbrication des entraves à la santé dans les trajectoires des exilé·es vivant en squat

FAYA ROBLES, A., BELTRAN, G. ET NICAISE, S.

2024

Revue française des affaires sociales 243(3): 49-69.

https://shs.cairn.info/revue-francaise-des-affaires-sociales-2024-3-page-49

L'article, issu d'une enquête qualitative par observations et entretiens conduite en 2021 et 2022, questionne les entraves à la santé auxquelles font face les personnes exilées vivant en squat à partir de leurs trajectoires migratoires, résidentielles et administratives, ainsi que les ressources et stratégies mobilisées par ces populations pour y faire face. Aux parcours de migration marqués par la violence et le dénuement succèdent des conditions d'accueil, en France, faites d'obstacles administratifs et d'aggravation de la pauvreté, dont l'habitat en squat témoigne. Autant d'aspects enchevêtrés, propres à une condition migrante dominée, qui affectent l'état de santé physique et psychique de ces populations, fragilisent leur accès aux soins et modifient leur rapport à la santé. L'analyse d'un dispositif sanitaire de type « aller-vers » déployé en squat permet de visibiliser les logiques d'illégalisation, d'humanitarisation et de racialisation présentes dans la prise en charge de ces populations. Elles imprègnent les représentations et les pratiques des intervenant·es et coproduisent de nouvelles limitations dans l'accès aux soins, tout en renforçant leur marginalisation sanitaire.

To what extent did mortality from COVID-19 in England and Wales differ for migrants compared to non-migrants in 2020 and 2021? A descriptive, observational study.

HIAM, L., MINTON, J., BURNS, R., *et al.*

2024

European Journal of Public Health 34(6): 1149-1156.

https://doi.org/10.1093/eurpub/ckae142

Seventeen percent of people living in the UK are migrants. In high-income countries, migrants have been shown to have better all-cause mortality but worse mortality for some specific causes such as infectious diseases. This observational study aims to quantify the extent to which mortality from coronavirus disease 2019 (COVID-19) differed between migrants and non-migrants for the population of England and Wales, 2020-2021. We use Official National Statistics data to compare mortality from COVID-19 in 2020 and 2021 by country/region of birth, expressed as the standardized mortality ratio with those born in England and Wales as the reference population. Migrants from 17 of 19 countries/regions examined had higher mortality from COVID-19 than non-migrants. The highest mortality was those born in Bangladesh (females SMR = 3.39, 95% CIs 3.09–3.71; males 4.41, 95% CIs 4.09–4.75); Pakistan (females 2.73, 95% CIs 2.59–2.89; males 3.02, 95% CIs 2.89–3.14); and the Caribbean (females 2.03, 95% CIs 1.87–2.20; males 2.48, 95% CIs 2.37–2.60). Migrants born in Antarctica and Oceania (females 0.54, 95% CI 0.42–0.40; males 0.71, 95% CI 0.51–0.88), and North and Central America (females 0.95, 95% CI 0.80–1.11; males 0.85, 95% CI 0.72–0.99) had lower mortality than non-migrants. Most migrant populations had higher mortality from COVID-19 than non-migrants in England and Wales. Policy-makers must work to integrate migration status into routine data collection to inform future research and understand the causes of the inequalities seen.

▶ Mobiliser des savoirs communautaires dans la médiation en santé : le cas de la PrEP parmi les femmes trans, migrantes, travailleuses du sexe, séronégatives

ISIP, K., PIGNEDOLI, C., VEGA, V., *et al.*

2024

Revue française des affaires sociales 243(3): 133-153.

https://shs.cairn.info/revue-francaise-des-affaires-sociales-2024-3-page-133

Cet article est issu de l'enquête opérationnelle « Personnes trans et PrEP » ayant une approche communautaire de la recherche. Dans un premier temps, il documente les parcours et les réalités de vie matérielles des femmes trans, migrantes, travailleuses du sexe (TDS), séronégatives au cours de la crise sanitaire liée au Covid-19, ainsi que les obstacles qu'elles rencontrent dans l'accès à la prophylaxie pré-exposition (PrEP) – un traitement préventif du VIH – et aux soins. Dans un deuxième temps, il documente les savoirs communautaires mobilisés dans la médiation en santé de deux associations pour accompagner ce groupe vers la PrEP. L'article repose sur l'interprétation descriptive d'entretiens avec des femmes trans, migrantes, TDS sous PrEP (n = 8) et des représentant·es d'associations (n = 9). Le cumul de mobilités induites par des facteurs structurels entrave l'accès au soin des femmes trans, migrantes, TDS. Les conditions de vie de cette communauté se sont davantage détériorées pendant la pandémie. Les profils communautaires et les savoirs expérientiels mobilisés dans la médiation en santé permettent le développement de stratégies d'« aller-vers » et de rétention dans les soins adaptés.

▶ Les limites du « tapis rouge ». Le cas de l'accès aux soins des exilés issus d'Ukraine en France en 2022

JOXE, L.

2024

Revue française des affaires sociales 243(3): 115-132.

https://shs.cairn.info/revue-francaise-des-affaires-sociales-2024-3-page-115

Pour évaluer la part minimale des entraves aux soins auxquelles peuvent être confrontées les populations exilées, cet article s'appuie sur un cas contre-intuitif et presque idéal-typique de la migration internationale : celui de l'accueil « à bras ouverts » autant par les autorités que par les citoyens français des exilés issus d'Ukraine en 2022. Dans ces conditions, quelles ont été les limites résiduelles de ce « tapis rouge » ? Fondé sur dix-neuf entretiens avec des familles exilées ainsi qu'une trentaine avec des acteurs institutionnels et associatifs dans la métropole lyonnaise, cet article met en évidence la persistance, malgré les mesures d'exception mises en place, de difficultés d'accès aux soins. Certaines sont intrinsèquement associées à l'urgence d'une situation de crise migratoire (non-recours, freins linguistiques, manque d'informations ou restriction des critères d'admission), d'autres, plus structurelles, sont liées au système de santé français (contenu du « panier de soins », délais d'obtention d'un rendez-vous ou frilosité des praticiens), et d'autres enfin, interculturelles, sont à l'origine d'incompréhensions entre les exilés et les acteurs de l'accueil et du soin.

▶ Focus : Lutter contre le décrochage financier en matière de soins : les apports successifs des aides à l'acquisition d'une complémentaire santé

KESTEMAN, N.

2024

Informations sociales 212(1): 91-95.

https://shs.cairn.info/revue-informations-sociales-2023-4-page-91

Le renoncement aux soins est une forme de décrochage institutionnel, mais il ne s'explique plus que partiellement par un problème de prestations sociales ; l'offre de soins et le rapport à la santé et au corps médical y contribuent également. S'agissant de l'aide à l'acquisition d'une complémentaire santé, quelques enseignements sont déjà accessibles concernant le nouveau dispositif de complémentaire santé solidaire (C2S). Toutefois, ce focus s'appuie également, à titre comparatif, sur l'évaluation des dispositifs précédant la C2S : la couverture maladie universelle complémentaire (CMU-C) et l'aide à l'acquisition d'une complémentaire santé (ACS).

Wealth-related inequalities in self-reported health status in the United States and 14 high-income countries

KYRIOPOULOS, I., MACHADO, S. ET PAPANICOLAS, I.

2024

Health Services Research 59(6): e14366.

https://doi.org/10.1111/1475-6773.14366

Abstract Objective To examine wealth-related inequalities in self-reported health status among older population in the United States and 14 European countries. Data Sources and Study Setting We used secondary individual-level data from Health and Retirement Survey (HRS) and the Survey of Health, Ageing, and Retirement in Europe (SHARE) in 2011 and 2019. Study Design In this cross-sectional study, we used two waves from HRS (wave 10 and 14) and SHARE (wave 4 and 8) to compare wealth-related health inequality across countries, age groups, and birth cohorts. We estimated Wagstaff concentration indices to measure these inequalities across three age groups (50–59, 60–69, 70–79) and two birth cohorts (1942–1947, 1948–1953) in the US and 14 European countries. Data Collection/Extraction Methods We performed secondary analysis of survey data. Principal Findings Focusing on older population, we found evidence of wealth-related inequalities in self-reported health status across several high-income countries, with the US demonstrating higher levels of inequality than its European counterparts. The magnitude of these inequalities with respect to wealth remained unchanged over the study period across all countries. Our findings also suggest that wealth-related health inequalities differ at different stages of workforce engagement, especially in the United States. This could be explained either by potential redistributive effects of retirement or by uneven survivor effect, as less wealthy may drop out of the observations at a greater rate partly due to their poorer health. Conclusions Wealth-related inequalities in self-reported health status are strong and persistent across countries. Our results suggest that there is meaningful variation across high-income countries in health-wealth dynamics that merits further investigation to better understand whether certain health or welfare systems are more equitable. They also highlight the need to consider social policy and wealth redistribution mechanisms as strategies for improving population health among the less wealthy, in the United States and elsewhere.

Épuiser la biolégitimité. La fragilisation du droit au séjour pour soins en France hexagonale

MANAC'H, L.

2024

Revue française des affaires sociales 243(3): 27-47.

https://shs.cairn.info/revue-francaise-des-affaires-sociales-2024-3-page-27

En France, un titre de séjour peut être attribué à un·e étranger·ère du fait de l'exceptionnelle gravité de sa maladie. Ce cadre légal, qui reconnaît une biolégitimité au corps souffrant de l'étranger·ère, est toutefois progressivement fragilisé. En mobilisant une approche ethnographique, cet article décrit les effets de la restriction de l'accès au droit au séjour pour soins à partir de cas d'étranger·ères séropositif·ves au VIH ou concerné·es par des pathologies psychiques. Il montre une sortie du paradigme de la biolégitimité et analyse ses conséquences sociales, statutaires, symboliques, émotionnelles et psychologiques pour les étranger·ères malades. À travers le prisme du découragement, il s'intéresse à ce que produit la répétition des entraves à la régularisation sur la santé des étranger·ères.

Socioeconomic inequalities in waiting times for breast cancer surgery

MATIAS, M. A., SANTOS, R., SICILIANI, L., *et al.*

2025

Health Economics 34(2): 203-224

https://onlinelibrary.wiley.com/doi/full/10.1002/hec.4906

Abstract Prompt access to cancer care is a policy priority in several OECD countries, because delayed access can exacerbate deleterious health outcomes. Access to care based on need remains a key pillar of publicly-funded health systems. This study tests for the presence of inequalities in waiting times by socioeconomic status for patients receiving breast cancer surgery (mastectomy or breast conserving surgery) in England using the Hospital Episode Statistics. We investigate separately the pre-COVID-19 period (April 2015–January 2020), and the COVID-19 period (February 2020–March 2022). We use linear regression models to study the association between waiting times and income deprivation measured at the patient's area of residence. We control for demographic factors, type and number of comorbidities, past emergency admissions and Healthcare Resource Groups, and supply-level factors through hospital fixed effects. In the pre-COVID-19 period, we do not find statistically significant associations between income deprivation in the patient's area of residence and waiting times for surgery. In the COVID-19 period, we find that patients living in the most deprived areas have longer waiting times by 0.7 days (given a mean waiting time of 20.6 days).

▶ Effets de la précarité administrative sur la santé des migrants âgés

NIYONSABA, E. ET MOULAERT, T.

2024

Revue française des affaires sociales 243(3): 71-90.

https://shs.cairn.info/revue-francaise-des-affaires-sociales-2024-3-page-71

Cet article s'intéresse aux effets de la précarité administrative sur la santé des migrants âgés en France. Adoptant une approche ethnographique, à partir d'une enquête qualitative auprès de migrants de plus de 60 ans d'origine extra-européenne (pays hors union européenne), nous explorons la diversité d'expériences vécues par ces aînés dans les démarches de régularisation de séjour en fonction de leur parcours de vie et des difficultés administratives auxquelles ils font face. Nous analysons également les risques que représente cette précarité administrative sur leur santé. L'analyse des entretiens montre que les enquêtés affichent une grande détermination dans leurs démarches, mobilisant des moyens multiples tels que la valorisation de parcours d'intégration, le recours au droit spécifique à la santé etc. pour faire valoir leurs droits. Pourtant, ces démarches sont souvent loin d'aboutir aux résultats escomptés, et la précarité administrative affecte profondément leurs conditions de vie, se traduisant notamment par une insécurité permanente et une vulnérabilité renforcée, particulièrement pour les femmes. Elle s'accompagne d'un isolement social subi et de risques de multimorbidité, de parcours de soins contraints voire d'abandon de soins. Ces résultats appellent à une réflexion sur les politiques préventives des inégalités de santé qui prennent en compte la situation administrative des personnes vulnérables.

▶ Pandemic Times and Health Care Exclusion: Attitudes toward Health Care Exclusion of Undocumented Immigrants

NUNEZ, C. V.

2025

Journal of Health Politics, Policy and Law 50(1): 1-21.

https://doi.org/10.1215/03616878-11513062

Context: Most of the 11 million undocumented immigrants living in the United States are excluded from government health care programs. Yet, health care inequities pose significant dangers to all members of society during a pandemic. This project explores to what extent undocumented immigrants, in the context of a pandemic, can be seen as deserving of access to government health care programs. Methods: The project's first survey experiment explores whether work ethic can affect perceptions of undocumented immigrants as deserving of government health care programs. The second survey experiment tests to what extent appeals to fairness and self-interest, during a pandemic, shape health care deservingness attitudes. Findings: The results show that respondents view undocumented immigrants as less deserving of health care than citizens, even when undocumented immigrants have a solid work history. The second survey experiment, however, shows that appeals to fairness and self-interest trigger substantial increases in support for undocumented immigrants among both Republicans and Democrats. Conclusions: The results suggest that while undocumented immigrants are seen as less deserving of access, appeals to fairness and self-interest can trigger increased support.

▶ Financial strain measures and associations with adult health: A systematic literature review

SAMUEL, L. J., ABSHIRE SAYLOR, M., CHOE, M. Y., *et al.*

2025

Social Science & Medicine 364: 117531.

https://doi.org/10.1016/j.socscimed.2024.117531

Despite growing attention to other social needs like food and housing insecurity, financial strain, defined as having difficulty making ends meet or lacking money for basic needs, is under-recognized. Inconsistent labels and measures have made the literature difficult to unify. We used many synonyms for financial strain to systematically identify 199 U.S. studies (316 papers) that used financial strain measures that were operationally consistent with our definition as predictors of health among adults. We thematically coded financial strain measures for content and synthesized evidence based on measure and methods. Financial strain was measured by self-reported lacking money for basic needs (119 studies) and/or difficulty making ends meet (n = 132), and less commonly additionally based on coping strategies (n = 23), satisfaction with finances (n = 14), worry about finances (n = 22), the anticipation of strain (n = 14), and/or lacking money for leisure (n = 29). Regardless of measure, financial strain was associated with poorer mental, physical, biological, and functional health, worse health behaviors and more social needs. Associations were found across diverse and population-based samples and when accounting for other socioeconomic factors and even intermediating health factors. Results demonstrate predictive validity for two different one-item screening tools. Furthermore, the vast evidence linking financial strain to health highlights an urgent need for policy action addressing financial strain to advance health equity.

▶ Do poor psychosocial resources mediate health inequalities in type 2 diabetes mellitus? Findings from the Maastricht study

SEZER, B., ALBERS, J., MEISTERS, R., *et al.*

2024

European Journal of Public Health 34(6): 1029-1035.

https://doi.org/10.1093/eurpub/ckae139

Low socioeconomic position (SEP) has been identified as a risk factor for type 2 diabetes mellitus (T2DM), and psychosocial resources might be on the pathway in this association. We examined two poor psychosocial resources, low control beliefs and inferiority beliefs, that might link low SEP with T2DM. 8292 participants aged 40–75 living in Southern Netherlands participated in The Maastricht Study starting from September 2010 to October 2020 and were followed up to 10 years with annual questionnaires. SEP (education, income, occupation), low control beliefs, inferiority beliefs, and (pre)diabetes by oral glucose tolerance test were measured at baseline. Incident T2DM was self-reported per annum. We analysed the mediating roles of poor psychosocial resources by using counterfactual mediation analysis. People with low SEP had more often prevalent and incident T2DM (e.g. low education: HR = 2.13, 95%CI: 1.53–2.97). Low control beliefs and high inferiority beliefs were more common among people with low SEP. Moreover, low control beliefs and high inferiority beliefs were risk factors for T2DM (e.g. low control beliefs: HR = 1.50, 95%CI: 1.08–2.09). The relationship between SEP and T2DM was partially mediated by control beliefs (8.0–13.6%) and inferiority beliefs (2.2–4.5%). We conclude that poor psychosocial resources are important in socioeconomic inequalities in diabetes. Researchers and practitioners should consider the psychosocial profile of people with lower SEP, as such a profile might interfere with the development, treatment, and prevention of T2DM. Further research should explore how poor psychosocial resources interact with chronic stress in relation to socioeconomic health inequalities.

▶ Understanding the health system drivers of delayed cancer diagnosis in public healthcare networks of Chile, Colombia and Ecuador: A qualitative study with health professionals, managers and policymakers

VARGAS, I., MOGOLLÓN-PÉREZ, A. S. ET EGUIGUREN, P.

2025

Social Science & Medicine 365: 117499.

https://doi.org/10.1016/j.socscimed.2024.117499

Although the greatest delays in cancer diagnosis in Latin America occur in the provider interval little is known about the related factors. This study aims to analyze factors influencing access to cancer diagnosis -from initial contact with health services to confirmation- from institutional stakeholders' perspective in public healthcare networks of Chile, Colombia, and Ecuador. A qualitative, descriptive-interpretative study was conducted in two networks per country, using semi-structured individual interviews (n = 118; 23 to 58, per country) with a criterion sample of health professionals and administrative personnel from primary care (PC) (n = 41) and secondary/tertiary care hospitals (n = 47), network managers and policymakers (n = 30). The final sample size was reached through saturation. Thematic content analysis was performed, segmented by country. The analysis reveals interacting factors that cause cumulative delays throughout the patient's diagnostic pathway within healthcare networks, with differences between countries. In all three, informants identify similar characteristics of the networks: structural (deficits in diagnostic resources; geographical accessibility), organizational factors (long waiting times, especially after referral), and the limited knowledge and experience of PC doctors, which all lead to delayed diagnosis. In Chile and Colombia, health policy barriers related to care rationing/prioritization policies that hampered access to tests, and in Chile, increased delays for non-prioritized conditions. Country-specific barriers related to the organization of healthcare system also emerge: in Chile, private services subcontracting and the voucher system for using them; in Colombia, the management of care by insurers (care authorizations; fragmented and short-term contracting of providers); and in Ecuador, underfunding of the system. The barriers most affect the elderly, those with low socioeconomic status, with limited support networks, and rural areas residents. The results reveal relevant barriers in access to timely cancer diagnosis which can and should be addressed with specific cancer diagnosis policies and general measures that strengthen public healthcare systems and networks.

Médicaments

Pharmaceuticals

▶ Réflexions sur l'évaluation des médicaments et leur mise à disposition face aux évolutions sociétales

BOUVENOT, G.

2025

Bulletin de l'Académie Nationale de Médecine 209(1): 49-56.

https://doi.org/10.1016/j.banm.2024.10.018

Résumé Les annonces, parfois relayées par un tapage médiatique, de futures mises à disposition de médicaments des cancers et des maladies rares présumés très efficaces, associées au souhait des patients et de leurs associations de disposer de ces produits « prometteurs » le plus vite possible, créent une situation nouvelle en matière de revendications d'autorisations de mise sur le marché et en France de prise en charge par la solidarité nationale. Cette situation, faite d'espoirs et d'impatience face à des promesses souvent inconsidérées, est propice à un accommodement préoccupant avec les exigences méthodologiques d'une évaluation rigoureuse de ces candidats-médicaments. Il peut en résulter des mises sur le marché de médicaments insuffisamment évalués, de balance bénéfices/risques incertaine ou même défavorable, comme en témoignent des retraits ultérieurs du marché qui font se poser, surtout s'ils sont tardifs, la question des risques que l'on a fait courir aux patients. À cette évolution, des mentalités s'ajoutent les demandes de plus en plus pressantes de chercheurs et de sociétés savantes d'utiliser des méthodes plus appropriées que l'essai comparatif randomisé conduit à l'aveugle pour évaluer les nouveaux traitements ciblés des cancers, les thérapies cellulaires ou géniques. Les revendications sociétales, prises en compte et relayées par les pouvoirs publics, sont donc de deux ordres : évaluer plus vite quitte à évaluer moins bien et savoir parfois changer de paradigme en matière d'évaluation quitte à se satisfaire d'un niveau de preuve dégradé. La Food and Drug Administration et l'European Medicines Agency donnent des droits à ces désidératas et ne font pas obstacle à la prise en compte des résultats d'études non comparatives ou même d'essais « basket » pour octroyer des autorisations conditionnelles. Toutefois, les enjeux sécuritaires de ces évolutions étant considérables, on ne doit pas s'étonner qu'à l'inverse, de nombreuses prises de position dans la littérature stigmatisent nombre d'autorisations octroyées comme inappropriées. Summary Are new marketing authorizations still reliable?

▶ Souveraineté et médicaments

VERNANT, J. P.

2024

Sève : les Tribunes de la santé (81): 77-81.

https://shs.cairn.info/revue-les-tribunes-de-la-sante-2024-3-page-77

Le prix toujours croissant des innovations thérapeutiques et l'explosion des pénuries touchant d'autres médicaments ont fait que depuis plusieurs années la question d'une production nationale ou européenne des produits de santé a été posée. Ainsi à plusieurs reprises le président de la République a fait part de son désir de rapatrier sur le territoire national la production de médicaments dans l'espoir d'une part, de prévenir les pénuries et d'autre part, de limiter la dérive des prix des innovations. Ce faisant il oubliait de préciser que dérive financière et pénurie concernent des produits différents selon qu'ils étaient toujours sous licence ou avaient au contraire perdu celle-ci et que la relocalisation quasi impossible pour les uns serait plus facile pour les autres.

Politique de santé

Health Policy

NHS action on social and economic development in England: vague national policy expectations

DUNN, P., ALLEN, L., BUZELLI, L., *et al.*

2025

Health Policy 151: 105194.

https://doi.org/10.1016/j.healthpol.2024.105194

Under recent reforms to the National Health Service (NHS) in England, NHS organizations have been given new objectives to contribute to social and economic development. Health systems in other high-income countries are pursuing related approaches. This paper analyses national policy documents to understand the framing of the NHS's new policy priorities on social and economic development. We focus on the role of NHS integrated care systems—area-based planning bodies responsible for managing NHS resources and coordinating local services. National policy is vague about what social and economic development means in practice. There is limited guidance on which approaches local organizations should prioritize, and which organisations are responsible for implementation. Greater clarity from national policymakers and an overarching framework to guide local action is needed to reduce the risk of inaction, poorly targeted interventions, and missed opportunities for learning and evaluation. Policymakers and health system leaders also need to be realistic about the limits of local action given the importance of national public policy choices in shaping the social determinants of health. Coordinated policy action and investment across government is needed to address underlying social and economic conditions.

Constructing a One Health governance architecture: a systematic review and analysis of governance mechanisms for One Health

FAIJUE, D. D., SEGUI, A. O., SHRINGARPURE, K., *et al.*

2024

European Journal of Public Health 34(6): 1086-1094.

https://doi.org/10.1093/eurpub/ckae124

The integration of human, animal, and environmental health in the One Health framework is crucial for tackling complex health and environmental issues. Governance structures in One Health initiatives are essential for coordinating efforts, fostering partnerships, and establishing effective policy frameworks. This systematic review, registered with PROSPERO, aims to evaluate governance architectures in One Health initiatives. Searches in PubMed, Scopus, WoS, and Cochrane from 2000 to 2023 were conducted. Key terms focused on peer-reviewed articles, systematic reviews, and relevant grey literature. Nine eligible studies were selected based on inclusion criteria. Data synthesis aimed to assess governance mechanisms' functionality and effectiveness. Among 1277 sources screened, nine studies across diverse regions were eligible. An adapted framework assessed implementation mechanisms of international agreements, categorizing them into Engagement, Coordination, Policies, and Financial domains. The findings highlight the importance of effective governance, stakeholder engagement, and collaborative approaches in addressing One Health's challenges. Identified challenges include deficient intersectoral collaboration, funding constraints, and stakeholder conflicts. Robust governance frameworks are pivotal in One Health paradigms, emphasizing stakeholder engagement and collaboration. These insights guide policymakers, practitioners, and researchers in refining governance structures to enhance human-animal health and environmental sustainability. Acknowledging study limitations, such as methodological variations and limited geographical scope, underscores the importance of further research in this area.

▶ L'optimisation du parcours de soin en cancérologie

LARTIGAU, É.

2025

Bulletin de l'Académie Nationale de Médecine 209(1): 80-86.

https://doi.org/10.1016/j.banm.2024.11.006

Résumé Le parcours de soin et son évaluation ont pris une place essentielle en cancérologie depuis une dizaine d'année. Un parcours va correspondre à la coordination d'acteurs du soin, internes ou externes à un établissement de santé, permettant une optimisation de la prise en charge. L'adhésion du patient, de ses proches-aidants et des acteurs du parcours va nécessiter une coordination, un partage d'informations et la présence d'acteurs nouveaux au cœur de ces dispositifs. Summary The notion of evaluated care pathways has taken an essential place in oncology over the past ten years. A care pathway will correspond to the coordination of care actors, internal or external to a health establishment, allowing for an optimization of care. The support of the patient, caregivers and medical and social professionals involved in the pathway will require coordination, information sharing and the presence of new actors at the heart of these systems.

▶ German centralization strategy during COVID-19: continuing or interrupting a trend?

NIEHAUS, I. M., LEHR, A., KAISER, A., *et al.*

2024

Health Policy 150: 105177.

https://doi.org/10.1016/j.healthpol.2024.105177

ABSTRACT In response to the COVID-19 pandemic, many countries applied centralization strategies to the distribution of power between national government and regional/local governments over responsibility for regulatory tasks. As a result, health-policy decision-making competences were shifted from the regional level to the national level (vertical shift of decision-making competences). This centralization trend for the purpose of infection control is evident in Germany. We conducted a quantitative and qualitative analysis of health-policy regulatory measures (March 2018 to March 2020) in order to investigate whether the vertical shift in decision-making competences was already a trend in Germany before the COVID-19 pandemic and beyond infection control. Our results show that the centralization strategy observed during COVID-19 does not continue a trend. Before the COVID-19 pandemic, what was most important was the distribution of power at national level between government and non-government institutions (horizontal allocation of decision-making competences). This long-term trend strengthens the decision-making competences of government institutions and weakens non-government institutions.

▶ Physical activity policy implementation and physical activity levels in the European Union: Are we on track to close the gap between policy and practice?

WHITING, S., ABU-OMAR, K., GELIUS, P., *et al.*

2025

Health Policy 151: 105200.

https://doi.org/10.1016/j.healthpol.2024.105200

National policies are a key starting point to achieve changes in population health. This study aimed to provide an overview of the relationship between physical activity policy implementation and the levels of sufficient physical activity across the European Union over the last decade. Data from the 23 indicators of the European Union Health-Enhancing Physical Activity Monitoring Framework established to monitor country implementation of the European Union Physical Activity Guidelines from 2015, 2018 and 2021, and physical activity prevalence data from the Special Eurobarometer on Sport and Physical Activity in 2013, 2017 and 2022 were analysed. European Union Member States significantly increased their physical activity policy implementation from 2015 to 2021 by 13.2% (63.30 ± 18.89 versus 76.51 ± 14.94 %, $p < 0.001$, 95% CI [-19.97, -6.45]). However, no significant change in levels of sufficient physical activity was found between 2013 and 2022 (60.59 ± 15.67 versus 61.70 ± 17.67 %, $p = 0.360$, 95% CI [-3.61, 1.39]). Additionally, most European Union countries are not on track to meet the targeted 10% relative reduction in levels of insufficient physical activity by 2025. Physical activity policies in the European Union do not appear to be related with the intended goal of increasing levels of physical activity. Policies may need to be reviewed and policy monitoring expanded, strengthened, and better integrated.

Prévention

Prevention

Facteurs sociaux de vaccination et réticences vaccinales des 60 ans et plus, en France

DHUOT, R.

2024

Santé Publique 36(6): 11-23.

https://stm.cairn.info/revue-sante-publique-2024-6-page-11

Introduction : les plus âgées sont particulièrement concernées par les problématiques relatives à la vaccination. La mise en place par les pouvoirs publics d'une campagne fortement incitative à la vaccination pour lutter contre les effets de la pandémie de COVID-19 offre l'opportunité de réinterroger les ressorts de la vaccination pour ce groupe démographique particulier. Méthode : une enquête par questionnaire en ligne a été administrée à 190 000 retraités résidant en logement ordinaire, âgés de 60 ans ou plus, tirés au hasard dans les fichiers de l'Assurance Retraite. Au moyen de régressions logistiques, sont estimés les effets propres des caractéristiques sociodémographiques des répondants sur la probabilité d'être vaccinés au moment de l'enquête. Une modélisation en 2 étapes permet d'estimer sans biais la probabilité de souhaiter être vaccinés des individus non-vaccinés. Résultats : les individus ayant des revenus faibles (OR : [2,45 : 2,79]), ceux qui ne vivent pas en couple (OR : [1,35 : 1,45]), les individus qui estiment que les confinements n'ont pas eu d'effets sur leurs contacts familiaux (OR : [1,49 : 1,68]) avaient une probabilité plus élevée de ne pas être vaccinés au moment de l'enquête. Les individus qui ont utilisé davantage internet, plutôt que d'autres médias, pendant la crise sanitaire, souhaitaient significativement moins être vaccinés (p).

Rapport 24-10. Améliorer la pratique des activités physiques, du sport et réduire la sédentarité à l'École, un enjeu de Santé Publique

GIUDICELLI, C. P. ET BIGARD, X.

2025

Bulletin de l'Académie Nationale de Médecine 209(1): 2-14.

https://doi.org/10.1016/j.banm.2024.11.002

Résumé En France, la pratique de l'activité physique par les enfants et adolescents est nettement insuffisante, alors que leur niveau de sédentarité ne fait que s'aggraver. Le manque d'activité physique va croissant avec l'avancée en âge, surtout chez les jeunes filles et les élèves d'établissements situés en zones défavorisées. Seuls 20 % des garçons et 10 % jeunes filles en situation de handicap atteignent les recommandations en activité physique émises par l'OMS. La sédentarité, autre comportement à risque pour la santé, affecte tout particulièrement les enfants et adolescents qui passent en moyenne 3 à 4h30 par jour devant un écran. Les états d'inactivité et de sédentarité des enfants et adolescents français constituent des environnements à risque de surpoids, obésité, maladies cardio-métaboliques à court- ou long-terme, affectant ainsi le bien-être, la qualité de vie et la santé à l'âge adulte. Cette situation a été récemment aggravée par la pandémie de COVID-19 qui par les restrictions imposées de pratique d'activité physique a créé un environnement favorable au développement du surpoids et de l'obésité. Modifier les comportements des jeunes afin d'augmenter le niveau d'activité physique et réduire leur sédentarité est donc plus que jamais une priorité de santé publique. Même si le rôle des parents est fondamental, l'école et l'environnement périscolaire tiennent une place importante pour changer le comportement des enfants et adolescents. C'est pourquoi l'Académie nationale de médecine recommande de pérenniser les mesures déjà mises en place, renforcer la place de l'EPS (en accordant une attention toute particulière aux jeunes filles, enfants en surpoids ou obèses), sensibiliser tous les enseignants à la lutte contre la sédentarité, impliquer les parents pour promouvoir les déplacements actifs vers l'école. Enfin, une attention toute particulière doit être portée sur la mise en place de programmes d'activité physique adaptés pour les enfants et adolescents en situation de handicap.

Does delivery matter? Examining pandemic vaccination preferences across time and countries using a discrete choice experiment.

KONG, Q., VRIES, H. D., POYRAZ, D. D., *et al.*

2024

Social Science & Medicine 366: 117637.

https://doi.org/10.1016/j.socscimed.2024.117637

Introduction: After a pandemic outbreak, designing and implementing an effective vaccine supply chain is key. The last-mile vaccine delivery (LMVD) – the last stage of the vaccine supply chain – is of particular importance. LMVD design choices, such as the delivery mode (e.g., mobile team or PODs) and the number and locations of PODs, affect "operational attributes" like travel time and waiting time. This paper aims to understand how operational attributes of LMVD systems impact vaccination preferences across different priority groups, pandemic stages, and countries. Methods: Adults in The Netherlands (N=473 in May 2021 and N=385 in January 2023), Italy (N=302 in March 2023), and Poland (N=303 in March 2023) completed an online discrete-choice experiment. Participants chose between two hypothetical LMVD systems (and opt-out) with five attributes: appointment flexibility, appointment delay, in-facility waiting time, travel time, and familiarity with personnel. Mixed logit models were used to estimate coefficients, based on which relative importance (RI) and vaccine uptake percentages were calculated. Results: Operational attributes have a significant impact on estimated uptake. Travel time was the most important attribute in all four studies. Appointment delay and in-facility waiting consistently ranked second or third. The impact of the choice of an LMVD system on uptake varies over time and by country. In The Netherlands, it was strong in 2023 (23.4%) but moderate in 2021 (12.6%). Similarly, it was strong in Italy 2023 (21.8%) and moderate in Poland 2023 (11.4%). The estimated impact also varied by priority group, and was minor (6.1%) for the elderly with poor health in The Netherlands 2021 study. Conclusion: Design choices for the LMVD system significantly impact vaccination preferences. Adapting these systems to different countries, time periods, and population groups is key for their effectiveness.

Intersectional inequities in colorectal cancer screening attendance in Sweden: Using decision trees for intersectional matrix reduction

PEDRÓS BARNILS, N. ET GUSTAFSSON, P. E.

2025

Social Science & Medicine 365: 117583.

https://doi.org/10.1016/j.socscimed.2024.117583

Colorectal cancer (CRC) represents a significant health burden worldwide, with existing inequities in incidence and mortality. In Sweden, CRC screening programmes have varied regionally since the mid-2000s, but the significance of organised screening for counteracting complex inequities in screening attendance has not been investigated. This study aimed to assess patterns of inequities in lifetime CRC screening attendance in the Swedish population aged 60–69 years by identifying intersectional strata at higher risk of never attending CRC screening. The research question is answered using decision trees to reduce the complexity of a full intersectional matrix into a reduced intersectional matrix for risk estimation. Participants were drawn from the cross-sectional 2019 European Health Interview Survey (N = 9,757, response rate: 32.52%). The Conditional Inference Tree (CIT) (AUC = 0.7489, F-score = 0.7912, depth = 4, significance level = 0.05) identified region of residence (opportunistic vs organised screening), country of origin, gender, age and income as relevant variables in explaining lifetime CRC screening attendance in Sweden. Then, Poisson regression with robust standard errors estimated that EU-born women living in opportunistic screening regions belonging to the 2nd income quintile had the highest risk of never attending CRC screening (PR = 8.54, $p < 0.001$), followed by EU-born men living in opportunistic screening regions (PR = 7.41, $p < 0.001$) compared to the reference category (i.e. people aged 65–69 living in organised screening regions). In contrast, only age-related differences in attendance were found in regions with organised screening (i.e. people aged 60–64 living in regions with organised screening (PR = 2.01, $p < 0.05$)). The AUC of the reduced intersectional matrix model (0.7489) was higher than the full intersectional matrix model (0.6959) and slightly higher than the main effects model (0.7483), demonstrating intersectional effects of the reduced intersectional matrix compared with the main effects model and better discriminatory accuracy than the full intersectional matrix. In conclusion, regions with long-established organised CRC screening programmes display more limited socio-demographic inequities than regions with opportunistic CRC screening. This suggests that organised screening may be a crucial policy instrument to improve equity in CRC screening, which, in the long run, has the potential to prevent inequities in colorectal cancer mortality. Moreover, decision trees appear to be valuable statistical tools for efficient data-driven simplification of the analytical and empirical complexity that epidemiological intersectional analysis conventionally entails.

Primary prevention in hospitals in 20 high-income countries in Europe – a case of not "making every contact count"?

RECHEL, B., DURVY, B., AUGUSTO, G. F., *et al.*

2025

Health Policy 151: 105199.

https://doi.org/10.1016/j.healthpol.2024.105199

This article provides a snapshot of primary prevention activities in hospitals in 20 European high-income countries, based on inputs from experts of the Observatory's Health Systems and Policies Monitor (HSPM) network using a structured questionnaire. We found that in the vast majority of countries (15), there are no systematic national policies on primary prevention in hospitals. Five countries (Cyprus, Finland, Ireland, Romania and the United Kingdom) reported systematic primary prevention activities in hospitals, although in one of them (Cyprus) this was due to the fact that small hospitals in rural areas or less populated districts host providers of primary care. In two of the five countries with systematic national policies on primary prevention, there are no incentives (financial or otherwise) to provide these interventions. The remaining three countries (Finland, Romania and the United Kingdom) report the existence of incentives, but only two of them (Romania and the United Kingdom) provide financial incentives in the form of additional funding. Only two of the 20 countries (Ireland and the United Kingdom) make explicit use of the Making Every Contact Count (MECC) approach. Overall, it can be concluded that there is little focus on primary prevention in hospitals in Europe, which may be seen as a missed opportunity.

Rapport 24-11. Offre de soins en cancérologie adulte

VILLET, R., LARTIGAU, É., BLAY, J. Y., *et al.*

2025

Bulletin de l'Académie Nationale de Médecine 209(1): 15-34.

https://doi.org/10.1016/j.banm.2024.11.013

Résumé La fréquence des cancers en France a doublé depuis trente ans. Malgré une organisation très structurée, il existe des difficultés et des inégalités territoriales de prise en charge tout au long du parcours de soins. Concernant la prévention, une analyse des besoins avec la recherche des populations concernées, une planification des offres et une évaluation des résultats sont indispensables. Les réunions de concertation pluridisciplinaire (RCP) doivent être inter établissements évitant des décisions « monolithiques » et facilitant l'accès aux techniques innovantes, aux protocoles de recherche clinique et aux RCP de recours. La caractéristique génomique des tumeurs est indispensable et repose sur la détection d'anomalies du génome effectuée de façon ciblée (test compagnon) ou de préférence d'une manière plus globale (séquençage haut débit : NGS). Une interaction entre pathologiste et biologiste moléculaire est indispensable avec des comptes rendus unifiés et standardisés. Pour la chirurgie pour lesquels des seuils d'activité et une gradation de soins ont été définis, la radiothérapie où une forfaitisation tarifaire par traitement, identique entre le public et le privé est en cours de mise en place et l'oncologie médicale, il est indispensable de créer des parcours territoriaux de soins équilibrés avec un engagement opposable entres centres de référence et centres de proximité. Une politique nationale incitant aux métiers orientés vers la cancérologie doit être largement proposée avec une qualification spécifique des chirurgiens oncologues et une amélioration des parcours professionnels pour les personnels paramédicaux. Les soins de support doivent débuter dès la prise en charge avec une articulation hôpital-ville.

Recommandations de dépistage en France : une revue systématique

MEUNIER, P. Y., MAIGA, K., MAILLET, D., *et al.*

2024

Santé Publique 36(5): 15-35.

https://stm.cairn.info/revue-sante-publique-2024-5-page-15

Introduction : Il n'existe pas de synthèse des dépistages recommandés en France. L'objectif de cette étude était d'identifier les recommandations de dépistage publiées par la Haute Autorité de santé (HAS), de décrire leurs caractéristiques et de les comparer avec celles de l'United States Preventive Services Task Force (USPSTF). Méthodes : Revue systématique des recommandations de dépistage publiées par la HAS et l'USPSTF. Résultats : Au total, 53 recommandations de la HAS et 67 recommandations de l'USPSTF ont été incluses. Celles de la HAS concernaient 74 pathologies, dont 67 à dépister, 6 à ne pas dépister et une à la balance bénéfices-risques incertaine. Celles de l'USPSTF concernaient 65 pathologies, dont 30 à dépister, 7 à ne pas dépister et 28 à la balance bénéfices-risques incertaine. Parmi les 67 pathologies à dépister selon la HAS, 16 étaient des pathologies cardio-vasculaires ou métaboliques (24 %), 11 des dépistages néonataux (16 %), 11 des infections (16 %), 9 des dépistages développementaux et sensoriels (13 %), 5 des problèmes psychosociaux (8 %), 5 des cancers (incluant une prédisposition génétique) (8 %), 4 des expositions environnementales (6 %) et 6 d'autres pathologies (9 %). Un quart des préconisations de la HAS comportaient un niveau de preuve gradé, dont 71 % avec un accord d'experts. Conclusions : La HAS recommande de dépister 67 pathologies, dont 4 cancers. L'élaboration de recommandations dédiées aux dépistages, issues d'une méthodologie appropriée et incluant la présentation de leur niveau de preuve, est attendue pour améliorer leur qualité et leur bon usage.

Psychiatrie

Psychiatry

La réforme du financement de la psychiatrie. Les établissements publics de santé mentale au défi du changement ?

ALARY, A.

2024

Gestions hospitalières 2024(639): 510-513.

Cet article évalue l'incitation au changement issue la réforme du financement de la psychiatrie pour les établissements publics de santé mentale. Trois messages clés se détachent. Tout d'abord, la réforme met en place un nouveau modèle de financement plus équitable, qui valorise davantage les dynamiques d'activité des établissements. Ensuite, si l'incitation à réorienter l'offre de soins apparaît faible, à paramètres de la réforme constants, les possibilités ouvertes par l'introduction de nouveaux concepts de financement imposent un suivi attentif des développements à venir. Enfin, il existe d'ores et déjà une incitation nette à améliorer les pratiques et organisations internes, dont découle un enjeu fort de conduite du changement avec la communauté médico-soignante.

The gendered impact of Covid-19 on health behaviours and mental health: Evidence from the UK

ARULSAMY, K., MCNAMEE, P. ET MENDOLIA, S.

2025

Social Science & Medicine 365: 117565.

https://doi.org/10.1016/j.socscimed.2024.117565

The purpose of this paper is to assess whether the COVID-19 pandemic affected the health behaviours of men and women differently, and to estimate whether the associations between health behaviours and mental health differed by gender. By employing nationally representative panel data (UKHLS) and a difference-in-differences strategy, we provide evidence that the pandemic adversely affected health behaviours among women more than men in the UK. Compared to men, women were 3.2 percentage points less likely to adopt a healthy lifestyle and reported 0.09 fewer healthy behaviours (corresponding to 7.0 per cent of a standard deviation) during the pandemic. These changes are primarily driven by smaller improvements rather than absolute declines in health behaviours for women compared to men. The changes in health behaviours among women appear to persist over time when lockdown policies were relaxed. Importantly, we find that the pandemic considerably weakened the protective effect of health behaviours on mental health for women but not for men. For women, adopting a healthy lifestyle was strongly correlated with mental health before the pandemic, but this relationship was no longer significant during the pandemic. This loss in significance corresponds to a 0.61-points decline in the GHQ-12 Likert score, equivalent to 10.5 per cent of a standard deviation. However, we observe a partial return of the protective effect of health behaviours on mental health once lockdown measures had eased.

Urban-rural disparities in hospital admissions for depression in Austria: A spatial panel data analysis

BERGER, M., ZUBA, M. ET SIMON, J.

2025

Health Policy 151: 105209.

https://doi.org/10.1016/j.healthpol.2024.105209

Medical practice variation in mental healthcare is a useful indicator for policymakers aiming to improve the efficiency of healthcare delivery. Previous studies have shown strong regional variation in healthcare utilisation in Austria, which seems to be a by-product of regionalised institutional rules and healthcare service mix rather than epidemiology. We use a set of routine municipality-level healthcare data on hospital admissions for depressive episodes of adult Austrian patients from 2009 to 2014 to examine spatial patterns in healthcare utilisation in mental health. Our data contains 93,302 hospital episodes by 65,908 adult patients across 2114 municipalities. We estimate a random-effects spatial autoregressive combined model to regress log hospital admission rates on hospital supply and urbanicity as proxies for municipality healthcare service mix alongside demographic and socioeconomic controls. We find that admissions for depression are substantially higher in suburban municipalities compared to rural areas and in municipalities with hospitals compared to those without. The spatial structure suggests positive spatial spillovers between neighbouring municipalities. Our main results are stable across virtually all model specifications used for robustness and show that healthcare service mix and supply of hospital services strongly correlate with spatial patterns of hospital admission rates in the population. Promoting timely access to high-quality primary care and early-stage treatments may reduce the burden of avoidable depression-related hospitalisations for patients and public budgets, and close a gap of unmet need for care of vulnerable populations.

Horizontal inequity in the use of mental healthcare in Australia

BLACK, N., JOHNSTON, D. W., KNAPP, M., *et al.*

2025

Health Economics 34(2): 297-315.

https://doi.org/10.1002/hec.4910

Abstract For people experiencing mental health problems, timely access to high-quality healthcare is imperative for improving outcomes. However, limited availability of services, high out-of-pocket costs, insufficient health literacy and stigmatizing attitudes may mean people do not receive the necessary treatment. We analyze Australian longitudinal data to document the extent and predictors of horizontal inequity in mental healthcare use among people with a newly developed mild or moderate mental disorder. Importantly, we compare people with similar health, residing in the same area, thus controlling for differences in healthcare needs and availability of services. Results suggest that mental healthcare use is not significantly associated with household income or financial hardship. In contrast, we find significant inequities by educational attainment, with university graduates around 50% more likely to receive mental healthcare than high-school dropouts. These findings are robust across subsamples and alternative modeling approaches, including panel data models with individual fixed-effects. Additional explorations of the education gradient suggest a potential pathway through mental health-specific knowledge and attitudes.

Incorporating Complexity and System Dynamics into Economic Modelling for Mental Health Policy and Planning

CROSLAND, P., MARSHALL, D. A., HOSSEINI, S. H., *et al.*

2024

PharmacoEconomics 42(12): 1301-1315.

https://doi.org/10.1007/s40273-024-01434-3

Care as usual has failed to stem the tide of mental health challenges in children and young people. Transformed models of care and prevention are required, including targeting the social determinants of mental health. Robust economic evidence is crucial to guide investment towards prioritised interventions that are effective and cost-effective to optimise health outcomes and ensure value for money. Mental healthcare and prevention exhibit the characteristics of complex dynamic systems, yet dynamic simulation modelling has to date only rarely been used to conduct economic evaluation in this area. This article proposes an integrated decision-making and planning framework for mental health that includes system dynamics modelling, cost-effectiveness analysis, and participatory model-building methods, in a circular process that is constantly reviewed and updated in a 'living model' ecosystem. We describe a case study of this approach for mental health system policy and planning that synergises the unique attributes of a system dynamics approach within the context of economic evaluation. This kind of approach can help decision makers make the most of precious, limited resources in healthcare. The application of modelling to organise and enable better responses to the youth mental health crisis offers positive benefits for individuals and their families, as well as for taxpayers.

Enjeux éthiques de la pratique infirmière en psychiatrie

EL-CHOUEIFATY, D., LEDESMA, E. ET SASSINE-KAZAN, R.

2025

L'Encéphale 51(1, Supplement): S39-S41.

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Résumé Les enjeux éthiques de la pratique infirmière en psychiatrie suscitent de multiples questionnements qui nécessitent des prises de décision qui reposent sur des fondements éthiques. Les questions relatives à l'information du malade, à son consentement éclairé aux soins et à la privation de sa liberté seront détaillées dans le cadre de la relation soignant-soigné qui se doit d'être thérapeutique mais surtout symétrique. Ethics issues relative to nursing practice in psychiatry raise consistent questioning, requiring a decision-making process based on ethical foundations. The questions relating to the patient's information, his informed consent to care and the deprivation of his liberty will be detailed in the context of the caregiver-patient relationship, which must be therapeutic but above all symmetrical.

Questions de santé mentale et de libertés au croisement des dilemmes soignants remontés aux espaces de réflexion éthique régionaux

HAZIF-THOMAS, C., DONNART, C. ET TRISTCHLER-LE MAÎTRE, M. H.

2025

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Résumé L'action des espaces de réflexion éthique régionaux ne concerne pas que le champ de la bioéthique contemporaine et porte aussi sur nombre de questions de santé mentale rencontrées dans la pratique clinique et le travail d'équipe. L'exercice de discernement de conflits de valeurs est une exigence éthique qui suppose de nourrir un vivre-ensemble se basant sur le « penser ensemble » pour chacun et pour tous : un devoir de résistance collégiale afin d'éviter des dérives potentiellement délétères tant sur le plan humain que thérapeutique. Porter l'accent sur la proportionnalité dans les décisions médicales complexes en santé mentale nécessite de concilier protection, sécurité, et respect des libertés fondamentales, tout en équilibrant l'intérêt général et les besoins individuels. Cet arbitrage nécessite de donner une place plus forte à la réflexion éthique, afin d'éviter des décisions purement centrées sur la dimension sanitaire et actées sans respect de la démocratie sanitaire. En Bretagne et partout en France, les saisines des cellules de soutien éthique mettent en évidence les défis rencontrés sur le terrain, notamment en ce qui concerne les décisions institutionnelles de gestion de crise pendant la pandémie de COVID-19 ou encore en ce qui concerne les soins de santé mentale en fin de vie ou même face à des pathologies résistantes aux traitements. Ces situations soulèvent des questions critiques sur le respect de la dignité et de l'humanité des personnes soignées. Le respect d'une éthique de la compréhension, faite de retenue et de juste mesure, faisant appel à la délibération collégiale dans ces situations, apparaît essentiel à déployer au quotidien. Dans le contexte de la fin de vie, le besoin de développer la psychiatrie palliative en France devient une priorité. Ce développement permettrait de proposer des soins plus justes, respectueux des libertés individuelles, et mieux adaptés aux besoins spécifiques des patients en grande souffrance psychique, en particulier dans les environnements de vie fragilisés tels que les Ehpad, afin d'assurer une meilleure articulation des principes de bienfaisance et de non-malfaisance.

Is there such a thing as emergency ethics in psychiatry? A cross-analysis of interventional cardiology and surgery

LEAUNE, E., POULET, E., LE BIHAN, P., *et al.*

2025

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https://doi.org/10.1016/j.encep.2024.11.005

Primary care mental health integration to improve early treatment engagement for veterans who screen positive for depression

LEUNG, L. B., CHU, K., ROSE, D. E., *et al.*

2024

Health Serv Res 59 Suppl 2(Suppl 2): e14354.
https://doi.org/10.1111/1475-6773.14354

OBJECTIVE: To examine the relationship between the penetration (or reach) of a national program aiming to integrate mental health clinicians into all primary care clinics (PC-MHI) and rates of guideline-concordant follow-up and treatment among clinic patients newly identified with depression in the Veterans Health Administration (VA). DATA SOURCES/STUDY SETTING: 15,155 screen-positive patients 607,730 patients with 2-item Patient Health Questionnaire scores in 82 primary care clinics, 2015-2019. STUDY DESIGN: In this retrospective cohort study, we used established depression care quality measures to assess primary care patients who (a) newly screened positive (score >/=3) and (b) were identified with depression by clinicians via diagnosis and/or medication (n = 15,155; 15,650 patient-years). Timely follow-up included >/=3 mental health, >/=3 psychotherapy, or >/=3 primary care visits for depression. Minimally appropriate treatment included >/=4 mental health visits, >/=3 psychotherapy, or >/=60 days of medication. In multivariate regressions, we examined whether higher rates of PC-MHI penetration in clinic (proportion of total primary care patients in a clinic who saw any PC-MHI clinician) were associated with greater depression care quality among cohort patients, adjusting for year, healthcare system, and patient and clinic characteristics. DATA COLLECTION/EXTRACTION METHODS: Electronic health record data from 82 VA clinics across three states. PRINCIPAL FINDINGS: A median of 9% of all primary care patients were seen by any PC-MHI clinician annually. In fully adjusted models, greater PC-MHI penetration was associated with timely depression follow-up within 84 days ($\Delta P = 0.5$; $SE = 0.1$; $p < 0.001$) and 180 days ($\Delta P = 0.3$; $SE = 0.1$; $p = 0.01$) of a positive depression screen. Completion of at least minimal treatment within 12 months was high (77%), on average, and not associated with PC-MHI penetration. CONCLUSIONS: Greater PC-MHI program penetration was associated with early depression treatment engagement at 84-/180-days among clinic patients newly identified with depression, with no effect on already high rates of completion of minimally sufficient treatment within the year.

Prendre soin des personnes âgées immigrées souffrant de troubles psychiques : trajectoires d'aide des familles

LIOGIER D'ARDHUY, J.

2024

Revue française des affaires sociales 243(3): 91-111.
https://shs.cairn.info/revue-francaise-des-affaires-sociales-2024-3-page-91

Cet article se fonde sur une enquête réalisée auprès de personnes âgées immigrées suivies en psychiatrie et auprès de leurs proches aidants. Nous avons analysé la place des familles dans les soins de santé mentale de leur proche. Face à des troubles difficilement discernables car invisibles et peu connus, les aidants s'engagent dans une trajectoire d'aide avec un degré d'investissement qui varie en fonction de ce qu'ils souhaitent et de ce qu'ils peuvent faire. Pour produire de l'aide, tout en composant avec la potentielle barrière linguistique de leur proche, ils s'articulent avec différentes sphères : leur sphère professionnelle, leur fratrie, les professionnels de santé et les institutions sociales et sanitaires. Si certains aidants parviennent à faire émerger des ressources consolidant la continuité de leur trajectoire d'aide, d'autres connaissent davantage d'entraves entraînant une discontinuité dans l'aide fournie. Il s'agit donc, dans cet article, de rendre visible les perpétuels jeux d'articulation, de désarticulation et de réarticulation que ces familles opèrent avec leurs différents interlocuteurs.

The United Nations Convention on the Rights of Persons with Disabilities and its relevance to French mental health system

OULIARIS, C., GILL, N., HANON, C., *et al.*

2025

L'Encéphale 51(1, Supplement): S2-S7.
https://doi.org/10.1016/j.encep.2024.11.003

Objectives The Convention on the Rights of Persons with Disabilities (CRPD) is a landmark international treaty which embeds the human rights of people with disabilities, including mental disabilities, into international law. We aim to demonstrate the relevance of the CRPD for the protection of human rights of people with mental illness in France. We begin with a broad overview of its development and implementation at the level of the international community, and then describe the situation in France. Conclusion Ratification of the CRPD by France in 2010 reflected the increasing recognition of human rights of people with disabilities. To date, the CRPD has inspired several initiatives in the field of mental health in France. As it is at the international level, in France, there remains significant room for advancement; particularly concerning the promotion and protection of economic, social and cultural rights, in addition to that of civil and political rights. Full realization of the principles of the CRPD requires input from all sectors of government and the whole of the community. Résumé Objectifs La Convention relative aux droits des personnes handicapées (CRPD) est un traité international historique qui intègre les droits humains des personnes handicapées, y compris les handicaps mentaux, dans le droit international. Notre objectif est de démontrer la pertinence de la CDPH pour la protection des droits humains des personnes atteintes de maladie mentale en France. Nous commençons par un large aperçu de son évolution et de sa mise en œuvre au niveau de la communauté internationale, puis nous décrivons la situation en France. Conclusion La ratification de la CDPH par la France en 2010 reflète la reconnaissance croissante des droits humains des personnes handicapées. À ce jour, la CDPH a inspiré plusieurs initiatives dans le domaine de la santé mentale en France. Comme au niveau international, en France, il reste des marges de progression importantes; notamment en ce qui concerne la promotion et la protection des droits économiques, sociaux et culturels, outre celle des droits civils et politiques. La pleine réalisation des principes de la CDPH nécessite la contribution de tous les secteurs de l'État et de l'ensemble de la communauté des professionnels.

▶ Le pont aux ânes de l'autonomie du patient en psychiatrie

RAVEZ, L.

2025

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https://doi.org/10.1016/j.encep.2024.11.008

Résumé En éthique des soins de santé, l'autonomie du patient est souvent considérée comme un principe fondamental, surpassant même les principes de bienfaisance, non-malfaisance et justice. Inspiré par les philosophies libérales (comme J.S. Mill) et les morales du devoir (notamment Kant), ce principe reconnaît la dignité humaine et le droit de chacun à prendre des décisions libres en matière de santé. Dans la pratique, cela se traduit par l'obligation pour les soignants d'informer clairement le patient et d'obtenir son consentement éclairé, tout en respectant le secret professionnel. Cependant, en psychiatrie, ce principe pose un défi particulier. Les troubles mentaux peuvent altérer la capacité décisionnelle des patients, compromettant ainsi leur autonomie. Des situations délicates surviennent lorsqu'un patient psychotique ou gravement dépressif refuse les soins nécessaires. Les soignants sont alors confrontés à des dilemmes éthiques : doivent-ils imposer un traitement « pour le bien » du patient, au risque d'adopter une approche paternaliste souvent critiquée aujourd'hui ? Ce dilemme révèle une tension entre l'autonomie individuelle et la réalité de la vulnérabilité humaine. Certains éthiciens suggèrent une approche plus relationnelle de l'autonomie, où les décisions du patient sont soutenues par son entourage et par les soignants, créant ainsi un cadre où l'autonomie s'exerce dans l'interdépendance. Dans cette perspective, l'aide apportée au patient ne nie pas son autonomie mais la soutient. Finalement, en psychiatrie, le respect de l'autonomie doit être nuancé, permettant dans certains cas le recours à des soins contraints pour protéger les intérêts fondamentaux du patient et de ceux qui l'entourent.

▶ Mental health of Australian frontline nurses during the COVID-19 pandemic: results of a large national survey

ZAMANZADEH, A., ECKERT, M., CORSINI, N., *et al.*

2025

Health Policy 151: 105214.

https://doi.org/10.1016/j.healthpol.2024.105214

This paper investigates the effects of quantitative and emotional work demands on burnout indices of emotional exhaustion, depersonalization and personal accomplishment, and mental health indices of anxiety, depression and stress, among Australian nurses and midwives. This research uses de-identified self-report survey data from approximately 11,000 Australian nurses and midwives during the pandemic. Linear and quantile regression analyses explore how working conditions affect different aspects of nurses and midwives' burnout and mental health. Results show how working conditions affect burnout and mental health heterogeneously depending on the severity of the mental health symptoms. Findings reveal that increased quantitative and emotional work demands significantly impact occupational burnout indices of emotional exhaustion and depersonalization, and mental health indices of anxiety, depression, and stress among Australian nurses and midwives during COVID-19. Results also reveal that quantitative and emotional demands have more significant effects on people with higher levels of anxiety, depression, stress, and depersonalization than those identified with milder or lesser symptoms. Given recent national and international policy focus on psychosocial hazards at work, this paper suggests that government and health care providers need to monitor such hazards among nurses and midwives and introduce policies that reduce excessive quantitative or emotional burden to minimise risk of burnout and poor mental health and support good mental health among Australian nurses and midwives.

Sociologie de la santé

Sociology of Health

Droits des malades et fin de vie en France, où en est-on en 2024 ?

BRETONNIÈRE, S.

2024

L'information psychiatrique 100(10): 785-790.

https://stm.cairn.info/revue-l-information-psychiatrique-2024-10-page-785

Le registre des droits des malades s'est étendu depuis la seconde moitié du 20^{e} siècle. Son principe fondateur est le consentement de la personne à la recherche médicale, aux traitements et soins. Les conditions du mourir et l'accès à une aide médicale à mourir est une préoccupation ancienne, qui participe de ce mouvement des droits des malades. Cet article présente une perspective historique et sociologique permettant d'en retracer la généalogie depuis les années 1960 et d'analyser la séquence qui s'est ouverte autour de la convention citoyenne sur la fin de vie en 2022-2023. Mon propos s'attache également à démontrer qu'un rééquilibrage de la relation médecin-malade est en cours, s'appuyant sur une autonomie qui s'affirme, faisant bouger les lignes du consentement, en se maintenant dans le registre des droits.

La responsabilité sociale en santé des médecins : analyse du premier tour d'un Delphi international

DE ROUFFIGNAC, S., MOKADDEM, N., TREUTENS, R., *et al.*

2024

Santé Publique 36(6): 75-84.

https://stm.cairn.info/revue-sante-publique-2024-6-page-75

Introduction : La définition de la responsabilité sociale en santé (RSS) pour les facultés de médecine a fait émerger l'enjeu d'en étendre la compréhension aux professions de la santé. Pour répondre à ce défi, le Réseau international francophone pour la responsabilité sociale en santé (RIFRESS) s'est d'abord focalisé sur le médecin, toutes spécialités confondues. But de l'étude : Cet article s'intéresse aux résultats du premier tour ouvert d'un Delphi visant à explorer les manifestations attendues chez un médecin engagé dans la RSS, selon l'opinion d'un groupe international francophone d'experts de la formation médicale. Un échantillon de type intentionnel d'experts a été invité à participer à partir de la liste des membres du RIFRESS afin d'assurer une diversité relativement à certaines caractéristiques. Le premier tour du Delphi consistait en un questionnaire fait de questions ouvertes invitant les participants à décrire les manifestations spécifiques d'un médecin qu'ils considèrent comme engagé dans la RSS. Les réponses ont ensuite fait l'objet d'une analyse thématique. Résultats : Trente participants présentant une diversité de profils ont fourni un total de 140 verbatim, regroupés en 13 thèmes. Conclusions : Les thèmes issus de cette étude font référence à des compétences d'expertise médicale inhérentes à la profession et, surtout, à des compétences comportementales essentielles pour une pratique médicale engagée dans la responsabilité sociale. Les valeurs de la RSS (qualité, équité, pertinence et efficience) sont au cœur des engagements du praticien.

Collaboration interprofessionnelle en service de chirurgie : les facteurs impactant la relation entre médecins en formation et infirmières

KOCK, A., MERDINGER-RUMPLER, C., GARTNER, J. B., *et al.*

2024

Journal de gestion et d'économie de la santé 3(3): 39-54.

https://shs.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2024-3-page-39

Face aux enjeux de la collaboration interprofessionnelle, considérée comme l'un des principaux leviers susceptibles d'améliorer la sécurité des patients et la qualité des soins, il apparaît pertinent de s'intéresser aux facteurs impactant la relation-clé entre médecins en formation et infirmières. L'objectif de notre recherche consiste à étudier les caractéristiques de cette relation pour en tirer des enseignements visant à favoriser la collaboration interprofessionnelle entre ces deux groupes. Une étude qualitative par entretiens semi-directifs auprès de 6 médecins en formation et de 6 infirmières a été menée dans un service de chirurgie digestive d'un Centre Hospitalier Universitaire français. Un traitement qualitatif inductif par codage ouvert des données a permis de faire émerger plusieurs résultats. Premièrement, la relation médecin en formation-infirmière apparaît comme une relation basée sur un objectif commun créateur de sens: la prise en charge sécurisée des patients. Ensuite, la relation d'interdépendance entre des professionnels exerçant des rôles différenciés les amène à développer de fortes attentes réciproques. Celles-ci se développent de manière accélérée dès le premier contact, résultant de l'accumulation d'expériences partagées en situation de travail. La confiance réciproque se construit, ou non, sur une exigence de compétence et d'implication des professionnels dans la prise en charge du patient. L'un des résultats principaux met l'accent sur les enjeux de perspectives temporelles différentes : la relation s'inscrit pour les médecins en formation dans une logique linéaire de parcours de formation, alors qu'elle s'inscrit pour les infirmières dans une logique circulaire de cycles d'accompagnement semestriel de cohortes d'internes.

The medical institution and transgender health: The role of healthcare barriers and negative healthcare experiences

STACEY, L., WISLAR, W. ET RECZEK, R.

2024

Soc Sci Med 365: 117525.

https://doi.org/10.1016/j.socscimed.2024.117525

Transgender health has risen as a topic of key interest. Yet little is known about factors that might stratify health among transgender people. In this paper, we suggest that the medical institution, which both prevents and provides access to transition-related care and thus sociolegal recognition for many transgender people, is a key institution for the health of transgender people. Drawing on 2015 US Transgender Survey data (USTS; N = 27,715), we examine whether transgender people who report barriers to healthcare and negative healthcare experiences have worse health than transgender people who do not. We contextualize the USTS sample against, and replicate our analyses when possible with, a probability-based sample of transgender people from the 2014-2017 Behavioral Risk Factor Surveillance System (BRFSS; N = 2,386). We find that transgender people who have unmet medical needs and negative healthcare experiences have worse self-rated health than their transgender counterparts who do not. Findings also suggest that such barriers and experiences are more negatively associated with the health of non-binary/genderqueer people compared with transgender men and transgender women. Our study moves past prior work documenting a transgender health disadvantage by identifying specific characteristics associated with poor health of transgender people and by illuminating heterogeneity in such associations.

Le temps soignant, fondement de la valeur partagée du soin

ZAGHMOURI, N.

2024

Journal de gestion et d'économie de la santé 3(3): 73-88.

https://shs.cairn.info/revue-journal-de-gestion-et-d-economie-de-la-sante-2024-3-page-73

La recherche présentée porte sur une analyse de la valeur du soin selon les perceptions singulières des multiples parties prenantes du soin, notamment les patients et les professionnels de santé. Elle vise à préciser les définitions de la valeur du soin et à explorer les mécanismes visant son amélioration à partir d'une analyse collective des tâches réalisées par les professionnels selon la méthodologie lean. A partir de la question de recherche suivante : comment améliorer la valeur partagée du soin à partir d'une analyse collective du travail selon l'approche lean nous ambitionnons d'identifier les critères partagés des valeurs du soin et de proposer une démarche collective visant son amélioration. Dans cette perspective, une étude de cas est menée au sein d'un service de soins hospitalier confronté à d'importantes difficultés organisationnelles sources d'une insatisfaction partagée des patients et des professionnels. Les investigations s'inscrivent dans une triangulation des sources de données associant entretiens semi-directifs, observations et analyse documentaire. Les résultats mettent en lumière une définition partagée de la valeur du soin autour du temps soignant. L'analyse collective du travail permet d'objectiver la part des tâches à valeur ajoutée à hauteur de 38% et d'engager un consensus sur les mesures visant la valorisation du soin et plus précisément le temps soignant. La discussion permet de revenir sur les apports, les perspectives et les limites de la recherche.

Soins de santé primaires

Primary Healthcare

The association between care integration and care quality

AARON, M. B., KERRISSEY, M., NOVIKOV, Z., *et al.*

2024

Health Services Research 59(6): e14214.

https://doi.org/10.1111/1475-6773.14214

Abstract Objective The study aims to analyze the relationship between care integration and care quality, and to examine if the relationship varies by patient risk. Data Sources and Study Setting The key independent variables used validated measures derived from a provider survey of functional (i.e., administrative and clinical systems) and social (i.e., patient integration, professional cooperation, professional coordination) integration. Survey responses represented data from a stratified sample of 59 practice sites from 17 health systems. Dependent variables included three quality measures constructed from patient-level Medicare data: colorectal cancer screening among patients at risk, patient-level 30-day readmission, and a practice-level Healthcare Effectiveness Data and Information Set (HEDIS) composite measure of publicly reported, individual measures of ambulatory clinical quality performance. Data Collection/Extraction Method We obtained quality- and beneficiary-level covariate data for the 41,966 Medicare beneficiaries served by the 59 practices in our survey sample. Study Design We estimated hierarchical linear models to examine the association between care integration and care quality and the moderating effect of patients' clinical risk score. We graphically visualized the moderating effects at ±1 standard deviation of our z-standardized independent and moderating variables and performed simple slope tests. Principal Findings Our analyses uncovered a strong positive relationship between social integration, specifically patient integration, and the quality of care a patient receives (e.g., a 1-point increase in a practice's patient integration was associated with 0.31-point higher HEDIS composite score, $p < 0.01$). Further, we documented positive and significant associations between aspects of social and functional integration on quality of care based on patient risk. Conclusions The findings suggest social integration matters for improving the quality of care and that the relationship of integration to quality is not uniform for all patients. Policymakers and practitioners considering structural integrations of health systems should direct attention beyond structure to consider the potential for social integration to impact outcomes and how that might be achieved.

Réguler la répartition des médecins libéraux sur le territoire. Quelles réponses aux enjeux économiques et de santé publique ?

BARNAY, T.

2024

Revue française des affaires sociales 244(4): 232-255.

https://shs.cairn.info/revue-francaise-des-affaires-sociales-2024-4-page-232

La baisse de la densité médicale de médecins actifs de moins de 70 ans attendue au cours des trois prochaines années nourrit des inquiétudes légitimes parmi les acteurs du système de santé, au premier rang desquels les patients. La liberté d'installation des médecins sur le territoire français produit des inégalités d'accès aux soins mais génère également des défaillances systémiques du système de soins conduisant à des dépenses de santé en excès dans les zones sur-denses en médecins et à une qualité des soins altérée dans les zones sous-denses. Cette situation caractérise typiquement ce que les économistes nomment une « défaillance de marché », c'est-à-dire une incapacité des acteurs du marché des soins à atteindre seuls un équilibre optimal économiquement (efficient), socialement désirable mais aussi conforme aux promesses de l'État-providence. Sur la base de la littérature économique, cet article a pour objet, d'une part, de justifier une intervention accrue et rapide des pouvoirs publics en matière de lutte contre les déserts médicaux, d'autre part d'interroger l'efficacité des mécanismes d'incitation monétaires ou non monétaires mobilisés ou à actionner.

▶ Do international medical graduates' recruitment policies help to overcome healthcare shortage areas in developed countries? A systematic review

BEDUCHAUD, L., CELINGANT, E., FAURE, C., *et al.*

2024

Health Policy 150: 105190.

https://doi.org/10.1016/j.healthpol.2024.105190

This review investigates the effectiveness of utilizing foreign physicians or International Medical Graduates to alleviate medical shortages in rural and underserved areas of developed countries. Conducted in February 2024, this systematic review follows PRISMA 2020 guidelines, analysing 15 English-language studies from the United States, Canada, Australia, and New Zealand. The focus is on comparing physicians with international graduation to national graduates in rural and underserved contexts. Results reveal diverse trends across countries: in the United States, national graduates are generally more represented in rural areas, while foreign physicians are more prevalent in Health Professional Shortage Areas. In Canada, foreign graduates are more common in rural areas, varying by province. Australia and New Zealand show foreign physicians practicing more in rural areas than national counterparts. This study underscores significant reliance on foreign physicians to mitigate rural healthcare disparities. While this strategy partially addresses immediate shortages, long-term effectiveness is uncertain due to retention and integration challenges. Future policies should focus on sustainable solutions for equitable healthcare access and physicians' retention in underserved areas. This review emphasizes also the need for Europe-specific studies and further evaluation of policy effectiveness.

▶ Attractivité des territoires et logique d'installation liée au site de formation : le cas des chirurgiens-dentistes

BLOT, M., TOUPENAY, S. ET BAS, A. C.

2024

Santé Publique 36(5): 89-98.

https://doi.org/10.3917/spub.245.0089

Introduction : Il existe une très forte hétérogénéité de la répartition de l'offre de soins en France. Cette différence entraîne des inégalités géographiques d'accès aux soins et impacte la santé des individus. C'est le cas notamment pour les soins dentaires. La difficulté de réguler la répartition de l'offre de soins dentaires appelle à l'étude des déterminants locaux de l'installation des dentistes d'un point de vue global, et notamment interroge sur le rôle des sites de formation. Objectifs : Ce travail a pour objectif d'analyser l'installation post-universitaire des chirurgiens-dentistes selon leur site de formation. Matériel et méthodes : Nous avons utilisé les données de l'Observatoire du Conseil National de l'Ordre des Chirurgiens-dentistes et mis en œuvre une cartographie des installations des diplômés en fonction de leur site de formation. Nous avons ensuite mené une analyse multivariée de la rétention des diplômés autour des unités de formation ainsi que de leur attractivité auprès des diplômés formés ailleurs. Résultats : Les jeunes diplômés s'installent principalement de façon dispersée autour des unités de formation les plus écartées et de façon très compacte autour des unités de formation ayant des formations voisines proches. Entre 21 et 66 % des diplômés s'installent dans le département de leur unité de formation initiale. La rétention augmente avec la présence d'un littoral (+17 %, p=0,030), c'est aussi le cas de l'attractivité des diplômés hors département. Cette dernière est également associée à un niveau de vie local important (+7,3, p=0,000) mais baisse avec la pluviométrie (-8 % de diplômés extérieurs, p=0,000).

Conclusion : La dispersion des diplômés dépend de la proximité avec les autres sites de formation et de caractères intrinsèques du territoire. S'il n'est pas possible d'intervenir sur ces derniers, la densification des sites de formation sur les territoires sous-dotés en chirurgiens-dentistes pourrait s'avérer pertinente.

▶ Why nurses quit: Job demands, leadership and voluntary nurse turnover in adult care in the Netherlands

BOLT, E. E. T., ALI, M. ET WINTERTON, J.

2024

Social Science & Medicine 365: 117550.

https://doi.org/10.1016/j.socscimed.2024.117550

Nurse turnover is a prominent issue in Dutch healthcare, causing staff shortages and operational disruptions. The literature reports myriad factors triggering nurse turnover, but little attention is given to how motives arise at multiple organizational levels and whether these affect distinct groups of nurses differently. Using qualitative and exploratory methods, we examine motives at multiple levels and for distinct nurse categories. We apply thematic and cluster analysis to motives from semi-structured interviews conducted between 2019 and 2020 with 56 nurses who left a healthcare employer but continued working in adult care in the Netherlands. We provide an empirical nuance to understanding and analysing motives by differentiating between all motives reported by each participant and the single most important motive: reported most responsible for their turnover decision. Our exploratory analysis suggests heterogeneity among nurses in their expressed multi-level and multifaceted motives. A universal theoretical model is, therefore, unlikely to explain and predict nurse turnover. Job-demands resources theory and leader-member exchange theory appear most relevant in explaining multi-level and multifaceted motives for two distinct groups of nurses. The most important motives explained by job-demands resources theory are hierarchy and structural changes. The most important motives explained by leader-member exchange theory include increased workload and not being listened to by leaders. Our study has significant managerial and policy implications, highlighting the need to develop different retention strategies tailored to distinct groups of nurses characterized by their expressed motives. The most important motives are within the control of the organization, suggesting scope for healthcare organizations to address nurse turnover more effectively.

▶ La rémunération des médecins libéraux

BRAS, P. L.

2024

Revue de droit sanitaire et social (Hors série): 39-52.

L'auteur de cet article envisage d'examiner la question de la rémunération des médecins libéraux sous trois aspects qui sont sujets à débats : la détermination des tarifs des actes ; la modes de rémunération des médecins ; le niveau de rémunération des médecins.

▶ Perceptions et motivations des jeunes médecins à exercer en zones désertifiées face aux incitations des élus locaux : entre discours stéréotypés et pratiques effectives

DAGOT, C.

2024

Revue française des affaires sociales 244(4): 256-284.

https://shs.cairn.info/revue-francaise-des-affaires-sociales-2024-4-page-256

Dans un contexte de forte pénurie médicale et d'inégal accès aux soins des populations sur certains territoires, les médecins généralistes sont incités à exercer dans les zones désertifiées. Cet article analyse la perception qu'ont les jeunes médecins généralistes de la désertification en lien avec la formation médicale et les motivations à l'installation. Malgré les incitations des politiques publiques régionales et locales de santé, le recueil qualitatif révèle que l'exercice, voire l'installation dans des zones désertifiées où les besoins de soins sont importants ne sont pas sans arbitrages professionnels et personnels de la part des jeunes médecins. Toutefois, derrière un discours convenu et stéréotypé, se repèrent des déterminants à l'installation qui ouvrent la voie à des orientations possibles, notamment en milieu rural.

▶ Infirmières en pratique avancée : un déploiement lent, qui se poursuit

REVUE PRESCRIRE

2024

Prescrire : la revue (493): 858-859.

Please Mind the Gap between Guidelines & Behavior Change: A Systematic Review and a Consideration on Effectiveness in Healthcare

GANDOLFI, S., BELLE, N. ET NUTI, S.

2025

Health Policy 151: 105191.

https://doi.org/10.1016/j.healthpol.2024.105191

Background & Objective This systematic review evaluates the impact of guidelines on healthcare professionals' behavior and explores the resulting outcomes. Methods Using PRISMA methodology, Scopus and Web of Science databases were searched, yielding 624 results. After applying inclusion criteria, 67 articles were selected for in-depth analysis. Results The studies focused on key clusters: Target behaviors, Effectiveness, Research designs, Behavioral frameworks, and Publication outlets. Prescription behavior was the most studied (58.2%), followed by other health-related behaviors (31.3%) and hygiene practices (10.4%). Significant behavior changes were reported in 46.3% of studies, with 17.9% showing negative effects, and 22.4% reporting mixed results. Quantitative methods dominated (56.8%), while qualitative methods (19.4%) and review designs (13.4%) were less common. Theoretical Domain Framework (TDF) and Behavior Change Wheel (BCW) were frequently used frameworks, with the UK and the USA contributing most studies. Medical doctors (44.8%) were the primary participants, followed by general healthcare providers (37.3%). Conclusions The study highlights the varied effectiveness of guidelines, with prescription behavior being the most investigated. Guidelines influenced behavior positively in less than half of the cases, and doctors were the primary focus, rather than nurses. The complexity of interventions suggests a need for further research to develop more effective behavioral interventions and to standardize methodological approaches to reduce clinical variation in healthcare.

Les professionnels de santé et leurs financeurs. Etude sur la «crise» des configurations juridiques

GINON, A. S.

2024

Revue de droit sanitaire et social (Hors série): 53-63.

Les conventions (avec l'assurance-maladie via les syndicats représentatifs) et les contrats (avec les organismes d'assurance maladie complémentaires dans le cadre des réseaux de soins) sont les deux outils principaux d'organisation des relations juridiques entre les professionnels de santé et les financeurs du système. L'article tente de distinguer les mutations expliquant la crise que vit ces configurations juridiques : tension du modèle économique sur lequel s'est construit le statut juridique des professions de santé exerçant en libéral ; mise sur le marché des professions de santé et l'évolution de la définition du soin ; crise de la «rhétorique» de la complémentarité entre l'AMO et l'AMC.

Predictors of Croatian Nurses' Turnover Intention: a cross-sectional study

GUSAR, I., SIJAN, D., SORIC, T., *et al.*

2025

Health Policy 151: 105198.

https://doi.org/10.1016/j.healthpol.2024.105198

ABSTRACT The turnover intention rate among nurses is very high both worldwide, and in Europe. It is related to personal and professional factors that contribute to the decision to leave or stay. This descriptive cross-sectional study aimed to identify the personal and professional predictors that contribute to nurses' turnover intention in Croatia. A convenient sample of 448 nurses employed in public general hospitals was used. The Practice Environment Scale of the Nursing Work Index questionnaire and the Turnover Intention Scale were applied. A logistic regression model was used to determine the associations between nurses' turnover intention and their personal and professional factors. The results indicate that both types of factors can influence nurses' turnover intention. The associations between turnover intention and personal factors such as age ($p = 0.033$), gender ($p = 0.023$), job satisfaction ($p < 0.001$), and social satisfaction ($p = 0.006$), were recorded. Nurse participation in hospital affairs ($p = 0.026$), and the nurse manager ability, leadership, and support of nurses ($p = 0.002$), which are professional factors were also associated with turnover intention. In order to prevent turnover intention, continuous measures need to be planned and implemented to increase nurses' satisfaction and improve their working environment.

The « parcours exercice professionnel »: A response to medical deserts. Letter

JEDAT, V., BRABANT, Y. *et al.*

2024

J Epidemiol Popul Health 72(6): 202794.
https://doi.org/10.1016/j.jeph.2024.202794

Evaluation of a Chronic Care Management Model for Improving Efficiency and Fiscal Sustainability.

KADREE, M. A., WIGGINS, P., THOMPSON, L., *et al.*
2025
American Journal of Public Health 115(2): 133-137.
https://doi.org/10.2105/AJPH.2024.307886

Chronic care management is effective. Barriers to program durability include dependence on the provider–nurse duo to carry out labor-intensive services and the lack of a fiscally sustainable model. Between January and October 2022, an expanded chronic care management team—consisting of a provider, nurse, community health worker, and pharmacist—conducted a four-month intervention in an ambulatory setting. This intervention, using a convenience sample of 134 Medicare patients with uncontrolled type 2 diabetes or hypertension, demonstrated statistically significant improvements in controlling type 2 diabetes (P < .01) and blood pressure (P < .001). Direct provider workload decreased, and the Medicare reimbursement rate was 85.5%. (Am J Public Health. 2025;115(2):133–137. https://doi.org/10.2105/AJPH.2024.307886)

Les professionnels de santé : des compétence(s) en tension

LAMI, A.
2024
Revue de droit sanitaire et social(Hors-série): 122-131.

Cet article examine les tensions qui entourent les compétences des professionnels de santé. Il constate que ces tensions récurrentes sont dommageables pour la prise en charge des patients et que les solutions qui ont été adoptées au fil des différentes réformes se voient confrontées à de nombreux obstacles.

Skilled nursing facility staffing shortages: Sources, strategies, and impacts on staff who stayed

LELAND, N. E., PRUSYNSKI, R. A., SHORE, A. D., *et al.*
2024
Health Services Research 59(6): e14355.
https://doi.org/10.1111/1475-6773.14355

Abstract Objective To examine skilled nursing facility (SNF) staffing shortages across job roles during the COVID-19 pandemic. We aimed to capture the perspectives of leaders on the breadth of staffing shortages and their implications on staff that stayed throughout the pandemic in order to provide recommendations for policies and practices used to strengthen the SNF workforce moving forward. Study Setting and Design For this qualitative study, we engaged a purposive national sample of SNF leaders (n = 94) in one-on-one interviews between January 2021 and December 2022. Data Source and Analytic Sample Using purposive sampling (i.e., Centers for Medicare & Medicaid quality rating, region, ownership) to capture variation in SNF organizations, we conducted in-depth, semi-structured qualitative interviews, guided a priori by the Institute of Medicine's Model of Healthcare System Framework. Interviews were conducted via phone, audio-recorded, and transcribed. Rigorous rapid qualitative analysis was used to identify emergent themes, patterns, and relationships. Principal Findings SNF leaders consistently described staffing shortages spanning all job roles, including direct care (e.g., activities, nursing, social services), support services (e.g., laundry, food, environmental services), administrative staff, and leadership. Ascribed sources of shortages were multidimensional (e.g., competing salaries, family caregiving needs, burnout). The impact of shortages was felt by all staff that stayed. In addition to existing job duties, those remaining staff experienced re-distribution of essential day-to-day operational tasks (e.g., laundry) and allocation of new COVID-19 pandemic-related activities (e.g., screening). Cross-training was used to cover a wide range of job duties, including patient care. Conclusions Policies are needed to support SNF staff across roles beyond direct care staff. These policies must address the system-wide drivers perpetuating staffing shortages (i.e., pay differentials, burnout) and leverage strategies (i.e., cross-training, job role flexibility) that emerged from the pandemic to ensure a sustainable SNF workforce that can meet patient needs.

Transformer l'incertitude en confiance dans le parcours de soin: place de la prise de décision partagée, freins et facilitateurs de son implémentation en France

MARSICO, G.
2025

Bulletin de l'Académie Nationale de Médecine 209(1): 41-48.

https://doi.org/10.1016/j.banm.2024.11.007

Résumé La prise en compte et la gestion de l'incertitude en médecine, exacerbée par la pandémie de Covid-19, souligne l'importance de la prise de décision partagée (PDP) pour inscrire cette incertitude dans une relation de confiance. La pandémie a mis en évidence la nature imprévisible des situations cliniques, renforçant la nécessité d'impliquer les patients dans les décisions concernant leur santé. En France, bien que la PDP soit soutenue par des politiques publiques et des recommandations de la Haute Autorité de Santé, sa mise en œuvre reste inégale. Les obstacles principaux incluent des freins culturels liés à une pratique médicale qui demeure encore paternaliste, un manque de formation des professionnels de santé aux techniques de communication nécessaires, et des contraintes organisationnelles qui rendent difficile l'intégration de la PDP dans la pratique quotidienne. L'article insiste sur l'importance d'une formation systématique des soignants pour les doter des compétences nécessaires à la communication des risques et à l'utilisation des outils d'aide à la décision. Ces outils, tels que des applications numériques et des brochures d'information, sont essentiels pour améliorer la satisfaction des patients, la qualité des décisions médicales et l'observance des traitements. De plus, l'émergence d'une culture centrée sur le patient et le renforcement de la littératie en santé sont identifiés comme des facilitateurs clés pour l'adoption de la PDP. En conclusion, l'article suggère que surmonter les obstacles actuels et promouvoir la formation continue sont essentiels pour faire de la PDP une norme en France, particulièrement dans un contexte où l'incertitude est omniprésente.

L'évolution des missions du pharmaciens d'officine en réponse aux besoins du système de santé français

MONZIOLS, M.

2024

Revue de droit sanitaire et social 2024(5): 827-844.

L'organisation des soins de premier recours évolue du fait d'un manque de médecins et de leur répartition génératrice de « déserts médicaux » . Face à ce constat, la répartition des presque 20 000 officines de façon équitable sur l'ensemble du territoire français présente des atouts pour faciliter l'accès aux soins de premier recours. Ainsi, le législateur a élargi ces dernières années les missions du pharmacien d'officine. Cette stratégie qui place le pharmacien d'officine comme un acteur majeur de la lutte contre les inégalités territoriales d'accès aux soins présente néanmoins des faiblesses du fait, d'une part, du défaut d'attractivité de la formation de pharmacie lié aux différentes réformes d'accès aux études de santé, et d'autre part, des conséquences de l'évolution des missions et de la formation initiale des pharmaciens en France alors que croît le nombre de pharmaciens de nationalité française titulaires d'un diplôme de pharmacien obtenu dans un autre État membre de l'Union européenne.

Les professionnels de santé : les architectures en question

MORET-BAILLY, J.

2024

Revue de droit sanitaire et social(Hors-série): 109-120.

Cet article propose une grille de lecture des évolutions qui touchent les professions de santé et leurs inscriptions techniques dans le domaine du droit. Il expose successivement la construction de la compétence des professionnels au sens juridique du terme, puis prête attention aux missions médicales aux professions médicales et des actes des auxiliaires médicaux, met en lumière un certain nombre de fissures dans cette organisation. Enfin, il expose des mécanismes juridiques permettant de passer outre ces blocages.

More doctors, better health? Consolidating evidence from Brazil's Mais Médicos program

ROCHA, R.

2025

Social Science & Medicine 364: 117559.

https://doi.org/10.1016/j.socscimed.2024.117559

In their paper "More Doctors, better health? A generalised synthetic control approach to estimating impacts of increasing doctors under Brazil's Mais Medicos Programme", Thomas, Millett, Soares and Hone add novel empirical evidence on the effects of Brazil's Programa Mais Medicos (PMM) on population health outcomes, reinforcing evidence that PMM has had limited effects: while PMM improved healthcare access in underserved regions, results show little impact on more extreme outcomes, such as mortality. Here I collect and connect evidence from the Brazilian context to discuss three potential explanations that, inter alia, could help us better understand why evidence from Thomas et al. (2024) as well as from previous research efforts points to a weak relationship between physician supply and population health. The potential explanations include health production complexity, system adaptability, and the increasing challenge of managing chronic diseases, emphasizing the need for more integrated healthcare approaches.

Development of an organizational typology of interprofessional primary care teams in Quebec, Canada: A multivariate analysis

RODRIGUEZ-DUARTE, M. A., FERNAINY, P., GAUVIN, L., *et al.*
2024

Health Policy 152: 105202.
https://doi.org/10.1016/j.healthpol.2024.105202

Background This study aimed to develop an organizational typology of Interprofessional Primary Care (IPC) teams in Quebec, Canada, by describing their organizational profiles and assessing the association between the characteristics of the populations served and the organizational profiles. Methods This cross-sectional study was carried out using a finite mixture model of the 2021 financial monitoring data from the Ministry of Health and Social Services of Quebec. The population consisted of all IPC teams in Quebec (N=368). A multinomial logistic model was used to study the association between the population characteristics and the organizational profiles. Results The analysis revealed that IPC teams were heterogeneous and could be classified into five distinct profiles varying in size, team composition, sector, type, and level of partnership. Pregnant women (odds ratio [OR] = 2.78, 95% confidence interval [CI] 1.98-3.91), disadvantaged patients ([OR] = 1.62, [CI] 1.15-2.28), patients receiving homecare support ([OR] = 1.85, [CI] 1.28-2.66) and rural patients ([OR] = 0.66, [CI] 0.50-0.86)) were more likely to be associated to the medium, public, university-affiliated, practitioner-oriented, low partnered profile compared to the very small, private, regular, high-partnered profile. Conclusion IPC teams can be characterized into five distinct profiles that are associated with the characteristics of the populations they serve. These results may help to better evaluate if the desired effects of IPC teams have been achieved.

Factors associated with intent to stay in the profession: an exploratory cluster analysis across healthcare professions in Switzerland

ROTH, L., GILLES, I., ANTILLE, E., *et al.*
2024

European Journal of Public Health 34(6): 1146-1148.
https://doi.org/10.1093/eurpub/ckae100

Retention issues are widespread within the health workforce. This cross-sectional study used data collected from 1707 healthcare professionals in 2022–23 to identify with k-means clustering groups of individuals sharing similar working experiences. These profiles were linked with varying levels of turnover intentions and a range of healthcare professions. While occupational therapists and paramedics reported in average better working conditions, registered nurses and intermediate caregivers reported the poorest experiences. In other clusters, salaries were high where work–life balance was low, and inversely. By learning from similarities and differences in the working conditions of diverse healthcare professionals, shared initiatives aimed at improving retention across professions can be facilitated.

Blocked paths, unequal trajectories: Examining the career outcomes of health professions graduates by race, gender, and place of education

SCHUT, R. A.
2025

Social Science & Medicine 364: 117522.
https://doi.org/10.1016/j.socscimed.2024.117522

Despite the need for more - and more diverse - health professionals to meet the U.S.' growing healthcare needs, qualitative research suggests that many health professions school graduates (HPGs) are tracked away from pursuing a health professions career. To what extent do HPGs' career trajectories vary across race, gender, and place of education (i.e., whether one received their health professions education in the U.S. or abroad)? Drawing on the National Survey of College Graduates, I identify that among 5,966 HPGs (medical, dental, veterinary, optometry, and podiatry school graduates), foreign-educated HPGs are less likely than U.S.-educated HPGs to become health professionals in the U.S. However, not all foreign-educated HPGs experience equal degrees of disadvantage; racially minoritized foreign-educated HPGs - and most strikingly, Asian foreign-educated men and women HPGs - demonstrate the lowest likelihoods of matriculating to a health professions career. Moreover, structural barriers, including initial U.S. visa status, significantly disadvantage foreign-educated HPGs on their path towards becoming practicing health professionals. Together, results suggest that the stunted career trajectories of foreign-educated HPGs might further stall the diversification of the health professions and limit the potential of immigrant HPGs to draw on their unique human capital post-migration. Findings both improve understanding of the contributors to the U.S. health professional shortage and advance sociological knowledge around how the health professions serve as key sites in the reproduction of inequality across axes of race, gender, and place of education.

▶ Scope of practice and opioid prescribing behavior of nurse practitioners serving Medicare beneficiaries

SHAKYA, S. ET PLEMMONS, A.

2025

Health Econ 34(2): 225-245.

https://doi.org/10.1002/hec.4904

Policymakers aiming to increase access to health care while simultaneously keeping costs low and quality high are considering expanding the practice authority and prescriptive authority of nurse practitioners in order to address primary care shortages. While we know this increases access, some researchers argue that the expansion of job autonomy of nurse practitioners can compromise the quality and safety of rendered medical services. This paper investigates quality and safety outcomes in prescribing behaviors of nurse practitioners who have prescribed opioids for Medicare Part D beneficiaries using a unique source of policy variation, nurse practitioners with the ability to prescribe medication who move to either states with or without physician supervision. We find that scope of practice expansions do not compromise quality and safety in terms of potential abuse or misuse of prescriptive authority.

▶ State Full Practice Authority Regulations and Nurse Practitioner Practice Autonomy: Evidence From the 2018 National Sample Survey of Registered Nurses

SLADE, E. P., DEPRIEST, K., COMMODORE-MENSAH, Y., *et al.*

2025

Medical Care Research and Review 82(1): 68-78.

https://doi.org/10.1177/10775587241282163

State full practice authority (FPA) laws are designed to permit NPs to practice autonomously from physicians. Little is known regarding how FPA laws affect NPs' practice autonomy in daily practice. This study used nationwide survey data from 20,830 NPs to estimate how NPs' practice autonomy differs between NPs in FPA and non-FPA states. NPs in states with FPA laws were more than twice as likely as NPs in non-FPA states to practice in clinic settings with no onsite physicians and were twice as likely to not have a physician collaborator. Associations between FPA laws and four other indicators of practice autonomy were positive but smaller in magnitude. States with FPA laws more than 10 years experienced larger changes in nurse practitioner (NP) autonomy compared with states with FPA laws in effect less than 10 years. FPA laws may promote the development of autonomous NP practice sites, thereby expanding access in underserved populations.

▶ Advanced practice nursing implementation in France: A mixed-method study

TONIOLO, J., BERGER, V., DEPLANQUE, A., *et al.*

2024

J Adv Nurs 80(12): 5076-5089.

https://doi.org/10.1111/jan.16303

AIM(S): To describe advanced practice nursing (APN) in the French healthcare landscape and to provide insights on how the role is defined and implemented and how the role is perceived by physicians. DESIGN: A mixed-method approach incorporating qualitative and quantitative data to offer a global understanding of APN implementation in France was used. METHODS: Data were collected through questionnaires and interviews with APNs and physicians in diverse healthcare settings in France. The questionnaire assessed the roles, relationships with physicians and patients and the perceived implementation success of APNs.

In-depth interviews explored experiences, definitions, challenges and perspectives of APNs. A thematic analysis was applied to the qualitative data to complete the quantitative exploration. Descriptive analyses were performed for quantitative data. RESULTS: A total of 41 APNs and 12 physicians were involved in this study between December 2022 and March 2023. The findings underscore APN as a pivotal, independent profession integrating advanced clinical expertise and interprofessional skills. The challenges encountered by APNs include role ambiguity, ongoing resistance and the need to address institutional barriers. Despite the fact that 73.2% of APNs reported that their role was well implemented, only 17.1% had clearly defined roles at the outset. CONCLUSION: This study revealed the dynamic and evolving nature of APN in France, highlighting its challenges and opportunities. Despite facing role ambiguity and resistance, APNs play a crucial role in the healthcare system. IMPLICATIONS FOR THE PROFESSION AND/OR PATIENT CARE: The results highlight the need for specific interventions to tackle challenges and facilitate successful integration of APN. These insights lay a foundation for future research and interventions aimed at boosting the impact and acceptance of APN in France, potentially influencing policy modifications and professional development. IMPACT: Problem Addressed: The study aimed to enhance comprehension of the implementation and role of advanced practice nursing (APN) in France. It focused on defining APN in the French context, identifying barriers and facilitators to its implementation and evaluating its impact. MAIN FINDINGS: The study revealed that APN in France is evolving with expanded competencies and clinical autonomy, but faces challenges like role ambiguity and professional resistance. Key findings include the successful integration of APNs in healthcare settings, positive relationships with medical doctors and patient satisfaction. However, the study also highlighted the necessity to resolve role ambiguity and to improve the understanding and acceptance of APN roles among healthcare professionals for successful APN integration. Impact of the research: This research will primarily impact healthcare systems and policy-making in France, guiding the future development and integration of APN roles. It is also relevant for healthcare professionals, particularly nurses and physicians, by providing information about the evolving nature of APN and its benefits in patient care. Globally, the study contributes to the broader discourse on APN, offering insights that could inform APN implementation strategies in other countries facing similar healthcare challenges. REPORTING METHOD: COREQ-STROBE. PATIENT OR PUBLIC CONTRIBUTION: No patient or public contribution.

▶ Effectiveness of community-based participatory research (CBPR) interventions on mental health outcomes: A systematic review

YAU, J. H., WONG, E. L. Y., KANAGAWA, H. S., *et al.*
2024

Social Science & Medicine 363: 117491.
https://doi.org/10.1016/j.socscimed.2024.117491

Community-based participatory research (CBPR) promotes the significant involvement of community members in research, which helps increase the effectiveness of specific interventions for community members. However, no reviews have investigated the effectiveness of CBPR interventions in mental health outcomes nor the adherence level to CBPR principles. Therefore, the objectives of the current study were to (1) examine the effectiveness of CBPR interventions on mental health outcomes and (2) assess the overall adherence to CBPR principles in existing mental health research. A systematic search was conducted in five databases for studies published between January 2000 and December 2022. We included 14 studies in this review based on our eligibility criteria. We assessed the effectiveness of quality appraisal and developed a four-dimensional rating scheme (degree of community involvement in the research process; level of shared decision-making between researchers and the community; level of contribution to community capacity building; level of addressing original health problems in the community) to assess the overall adherence to CBPR principles. Although CBPR interventions impacted mental well-being outcomes, research quality varied, and most studies did not adhere to CBPR principles. Future research using the rating scheme proposed in this study is recommended.

Système de santé

Health System

Aligning quality improvement, research, and health system goals using the QUERI priority-setting process: A step forward in creating a learning health system

BECK, K. L., KILBOURNE, A. M., GIDMARK, S. I., *et al.*

2024

Health Serv Res 59 Suppl 2(Suppl 2): e14388.

https://doi.org/10.1111/1475-6773.14388

Timely generation and use of research evidence and methods to benefit patients, providers, and health systems continues to be a challenge for many health systems. The Quality Enhancement Research Initiative (QUERI) was established under the Office of Research and Development to help close this gap in the Department of Veterans Affairs (VA) health care system, the largest national integrated health system in the United States, by accelerating the uptake of research findings into health care practice and policy.1, 2 QUERI funds investigators embedded in VA health care facilities to partner with multilevel leaders, providers and other frontline staff, managers, and Veterans to scale-up, spread, and sustain promising and evidence-based practices that address the needs of Veterans and the health system.

Bridging borders: Current trends and future directions in comparative health systems research.

BOWDEN, N., FIGUEROA, J. F. ET PAPANICOLAS, I.

2024

Health Serv Res 59(6): e14385.

https://doi.org/10.1111/1475-6773.14385

Over the last two decades, comparative health systems research has gained significant traction as policymakers and researchers seek to better understand how to improve the effectiveness and efficiency of health-care systems worldwide. While most studies undertaken to achieve these goals continue to be predominantly at the national or sub-national levels, the role and importance of cross-country comparison research is increasingly being acknowledged. Recent challenges such as the COVID-19 pandemic, inflationary pressures, rising health-care costs globally, climate change, and decreasing life expectancy among several high-income countries have increased the importance and urgency of this work. Collaborative research efforts across disciplines and countries are therefore needed to identify focused solutions that health systems can apply to the challenges they currently face, and those that may arise in the future.

How COVID-19 Illness Perceptions and Individual Shocks are Associated with Trust during the COVID-19 Pandemic in Australia, France, Germany, and South Africa

BROIHANNE, M. H., PLOTKINA, D., KLEIMEIER, S., *et al.*

2025

Health Policy 151: 105178.

https://doi.org/10.1016/j.healthpol.2024.105178

The COVID-19 pandemic jeopardized individuals' health and economic stability, and the associated shocks might have decreased individuals' trust. In this paper, we study the relationship between subjective perceptions of the pandemic and individuals' institutional and interpersonal trust (e.g., trust towards the government or health representatives), while considering objective health and economic shocks due to the pandemic as drivers. We collected data across Australia, France, Germany, and South Africa during a later stage of the COVID-19 pandemic (i.e., from mid-April to early-June 2021) when individuals had time to personally experience the pandemic and its effects. COVID-19 illness perception was associated with lower institutional and interpersonal trust. The health shock of having experienced COVID-19 was associated with higher interpersonal trust, while economic shocks were associated with lower institutional trust when they were due to the pandemic. The results suggest that public policy interventions in a later stage of a pandemic should consider objective economic and health outcomes as well as subjective ones, such as individual's perceptions. Authorities should communicate in a way that helps concerned people understand that they can take control of their health and the possibility of infection, and reassure them that health measures such as vaccination can help prevent the spread of the virus.

The role of socio-economic determinants in the interregional allocation of healthcare resources: some insights from the 2023 reform in the Italian NHS

FANTOZZI, R., GABRIELE, S. ET ZANARDI, A.

2024

Health Policy 152: 105240.

https://doi.org/10.1016/j.healthpol.2024.105240

This paper discusses a reform recently implemented in the Italian National Health Service (INHS), aimed at adding some socio-economic indicators to the criteria adopted for allocating healthcare funding to Regions. The reform is based on international experience in healthcare financing in decentralized settings and provides a case study of special interest since Italy is a country with significant territorial disparities and severe budget constraints. The paper first discusses the long-standing debate between Italian Regions which led to the reform. Second, the main features of the reform are reviewed, with the inclusion of socio-economic indicators via a simplified formula. Moreover, a possible revision of the reform is proposed, fully exploiting, unlike now, the heterogeneity of health needs according to age and socio-economic indicators. By integrating the information on deprivation inside the mechanism, the weight of the different drivers is determined by the distribution of needs and not on a discretionary basis. Simulating the proposed revision suggests that more resources could be allocated to the Regions with higher levels of deprivation compared to a scenario that closely replicates the reform.

Health system resilience during the COVID-19 pandemic: A comparative analysis of disruptions in care from 32 countries

LEDESMA, J. R., CHRYSANTHOPOULOU, S. A., LURIE, M. N., *et al.*

2024

Health Serv Res 59(6): e14382.

https://doi.org/10.1111/1475-6773.14382

OBJECTIVE: To quantify disruptions in hospitalization and ambulatory care throughout the coronavirus disease 2019 (COVID-19) pandemic for 32 countries, and examine associations of health system characteristics and COVID-19 response strategies on disruptions. DATA SOURCES: We utilized aggregated inpatient hospitalization and surgical procedure data from the Organization for Economic Co-operation and Development Health Database from 2010 to 2021. Covariate data were extracted from the Organization for Economic Co-operation and Development Health Database, World Health Organization, and Oxford COVID-19 Government Response Tracker. STUDY DESIGN: This is a descriptive study using time-series analyses to quantify the annual effect of the COVID-19 pandemic on non-COVID-19 hospitalizations for 20 diagnostic categories and 15 surgical procedures. We compared expected hospitalizations had the pandemic never occurred in 2020-2021, estimated using autoregressive integrated moving average modeling with data from 2010 to 2019, with observed hospitalizations. Observed-to-expected ratios and missed hospitalizations were computed as measures of COVID-19 impact. Mixed linear models were employed to examine associations between hospitalization observed-to-expected ratios and covariates. PRINCIPAL FINDINGS: The COVID-19 pandemic was associated with 16,300,000 (95% uncertainty interval 14,700,000-17,900,000; 18.0% [16.5%-19.4%]) missed hospitalizations in 2020. Diseases of the respiratory (-2,030,000 [-2,300,000 to -1,780,000]), circulatory (-1,680,000 [-1,960,000 to -1,410,000]), and musculoskeletal (-1,480,000 [-1,720,000 to -1,260,000]) systems contributed most to the declines. In 2021, there were an additional 14,700,000 (95% uncertainty interval 13,100,000-16,400,000; 16.3% [14.9%-17.9%]) missed hospitalizations. Total healthcare workers per capita (beta = 1.02 [95% CI 1.00, 1.04]) and insurance coverage (beta = 1.05 [1.02, 1.09]) were associated with fewer missed hospitalizations. Stringency index (beta = 0.98 [0.98, 0.99]) and excess all-cause deaths (beta = 0.98 [0.96, 0.99]) were associated with more missed hospitalizations. CONCLUSIONS: There was marked cross-country variability in disruptions to hospitalizations and ambulatory care. Certain health system characteristics appeared to be more protective, such as insurance coverage, and number of inputs including healthcare workforce and beds. WHAT IS KNOWN ON THIS TOPIC: Substantial disruptions in health services associated with the coronavirus disease 2019 pandemic have placed a renewed interest in health system resilience. While there is a growing body of evidence documenting disruptions in services, there are limited comparative assessments across diverse countries with different health system designs, preparedness levels, and public health responses. Learning and adapting from health system-specific gaps and challenges highlighted by the pandemic will be critical for improving resilience. WHAT THIS STUDY ADDS: All countries experienced disruptions to hospitalizations and surgical procedures with a combined total of 30 million missed hospitalizations and 4 million missed surgical procedures in 2020-2021, but there was marked cross-country heterogeneity in disruptions. Countries with greater baseline healthcare workers, insurance coverage, and hospital beds had disproportionately lower disruptions in care. National health planning discussions may need to balance health system resiliency and efficiency to avert preventable morbidity and mortality.

Pandemic income support programs and adolescent mental health in the UK, Ireland, and Australia

MARI, G.
2025
Social Science & Medicine 365: 117612.
https://doi.org/10.1016/j.socscimed.2024.117612

After cutting social security in recent decades, the UK, Ireland, and Australia expanded income-support programs during the pandemic. Relatively overlooked, this paper investigates policy responses among younger generations, the socioeconomic disparities therein, and whether and which of these policies, now rolled back, were most beneficial. I rely on longitudinal survey data on adolescents and their caregivers. In value-added regressions adjusting for pre-pandemic health reports, I find that children reported better average health in households with access to the relatively generous scheme adopted by Australia. Girls reported better health in households targeted by previous cutbacks, including those with lower incomes (Australia, Ireland) or headed by a single parent (Australia). The more far-reaching programs in Ireland and Australia were associated with better health also among children in well-off households. On the other hand, some children reported worse mental health despite receipt of payments in the UK and Ireland. Further distributional analyses suggest that programs might have reduced adolescent health disparities in Australia, whereas overall effects were negative or mixed in the UK and Ireland. Hence, policy changes during the pandemic did not equally fit the needs of all children. Nonetheless, drawing lessons from that period, changes to existing income-support programs hold some promise to temper distress and associated inequalities across generations.

Using outcome measures in sub-national level performance management: When and under what circumstances?

SILWAL, P., TENBENSEL, T., EXETER, D., *et al.*
2025
Health Policy 151: 105195.
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There is growing interest in using outcome-based measures in sub-national level health system performance management, particularly in high-income countries. Increasingly, population health indicators used for making international comparisons are being applied at a sub-national level. This study aims to understand whether and under what circumstances population health outcome-based measures can be used for performance measurement and management at the sub-national level health systems. We have integrated empirical population-based data with key health system expert perspectives to evaluate the appropriateness of two population health indicators – amenable mortality and ambulatory-sensitive hospitalization of young children. Our assessment focused on two key aspects: (i) the technical validity of these indicators, ensuring they accurately measure these outcomes, and (ii) the functionality and legitimacy of performance information, determining whether it meets stakeholders' program or policy needs and supports strategic decision-making. Overall, we found that the 'intermediate' outcome measure, childhood ambulatory sensitive hospitalization, was more useful for identifying district-level health system performance variation than the 'end' outcome measure, amenable mortality. Performance information based on childhood ambulatory-sensitive hospitalization is more appropriate for improving decision-making, and it is more likely to be accepted by a wide range of stakeholders involved in health system performance improvement.

Travail et santé

Occupational Health

Balancing work and earnings: The long-term impact on mental health

CHEN, J. H., YANG, Y., FANG, C., *et al.*

2025

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Earnings and work hours (e.g., weekly work hours) are key determinants of one's mental health. While higher earnings are linked to better mental health due to reduced financial stress, they may come at the cost of longer work hours harmful for mental health. Therefore, balancing work hours with earnings is crucial for mental health. Using the 2015, 2017, and 2019 waves of the Panel Study of Income Dynamics (N = 6,776), this study explores how one's earnings and work hours combine to influence mental health using growth mixture modeling and a negative binomial regression model, with generalized propensity score weighting for causal inference. The findings reveal that working 40 h a week with earnings two to three times the US federal poverty threshold benefits mental health. However, earning more by working 60 h a week does not provide additional mental health benefits. Additionally, individuals with a history of low earnings face a high risk of psychological distress, even as their earnings improve over time. This risk is similar to that experienced by those consistently earning low incomes. Our findings highlight the importance of clarifying work-earning balance for one's mental health as well as identifying people with mental health needs from a longitudinal perspective.

Absenteeism and presenteeism among caregivers of chronic diseases: A systematic review and meta-analysis

DAS, N., MAJUMDAR, I. K., AGIUS, P. A., *et al.*

2024

Social Science & Medicine 363: 117375.

https://doi.org/10.1016/j.socscimed.2024.117375

Introduction Productivity-adjusted life-year (PALY) is a relatively new measure for quantifying the impact of disease on productivity. This study aims to systematically review the productivity factors such as absenteeism and presenteeism among informal caregivers of patients with a wide range of chronic health conditions to inform the PALY quantifications. Method A literature search across MEDLINE, Embase, EconLIT, PsychInfo, and CINAHL identified 3,578 studies from which a final 23 studies were included in the analysis. To explore the pooled estimate of caregiver absenteeism/presenteeism across diseases and possible drivers, a meta-analysis and meta-regression were conducted using studies where relevant data was available. Result The pooled proportion for absenteeism, presenteeism, and work productivity loss (WPL) was 14% (95% Confidence Interval [CI]:9-19%; I2=96.3%), 32% (95% CI:22-42%; I2=98.0%) and 44% (95% CI:35-53%; I2=95.4%) respectively with a high a level of heterogeneity. Factors such as the disease type, disease severity, and socio-economic factors can influence the caregivers' work productivity. Conclusion The data derived in this study will enable the derivation of productivity indices to estimate PALY among caregivers. Future studies can explore the work productivity impact among caregivers of patients with other chronic conditions where they have a significant role but are unexplored, and severity-wise studies in conditions such as stroke and dementia to understand the caregivers' societal productivity impact.

The effect of a minor health shock on labor market outcomes: The case of concussions

FOUQUET, F., MEEHAN, L., PACHECO, G., *et al.*

2024

Health Econ 33(12): 2838-2853.

https://doi.org/10.1002/hec.4897

The literature on health shocks finds that minor injuries have only short-term labor market impacts. However, mild traumatic brain injuries (mTBIs, commonly referred to as concussions) may be different as the medical literature highlights that they can have longer-term health and cognitive effects. Moreover, TBIs are one of the most common causes of disability globally, with the vast majority being mild. Thus, it is important to understand the impact of mTBIs on labor market outcomes. We use administrative data on all medically-diagnosed mild traumatic brain injuries (mTBIs) in New Zealand linked to monthly tax records to examine the labor market effects of a mTBI. We use a comparison group of those who suffer a mTBI at a later date to overcome potential endogeneity issues, and employ a doubly-robust difference-in-differences method. We find that suffering a mTBI has negative labor market effects. Rather than dissipating over time, these negative effects grow, representing a decrease in employment of 20 percentage points and earning losses of about a third after 48 months. Our results highlight the need for timely diagnosis and treatment to mitigate the effect of mTBIs to reduce economic and social costs.

▶ Does the health of local populations modify occupational differences in employment rates of older workers? Findings from the ONS Longitudinal Study 2001–2011

HEAD, J., NORMAN, P., SHELTON, N., *et al.*

2024

Health & Place 90: 103376.

https://doi.org/10.1016/j.healthplace.2024.103376

Poor health is a key reason for early exit from the labour market. Few studies have explored how the health of local populations is related to occupational differences in employment outcomes among older people. Our study used data for England and Wales from the ONS Longitudinal Study linked with 2001 Census measures of the health of the older working age population at local authority level. We included 128,710 people aged 40-64y in 2001 who were in paid work in the previous five years. We investigated the associations of both occupation and area level with two employment outcomes ten years later (in 2011): i) in paid work or not; ii) economic activity (employed (reference), unemployed, retired, sick/disabled, other). People in elementary occupations were more likely to not be in paid work in 2011 compared to those in managerial occupations (RRR 1·55 [95%CI 1·47,1·64]). Compared to the healthiest third of local authority areas, being resident in the unhealthiest third was associated with greater likelihood of not being in paid employment ten years later (RRR 1·25 [95% CI 1·18,1·33]). While area level health was associated with employment outcomes for all major occupation groups, the gap between the healthiest and unhealthiest areas was most marked for skilled trades; process, plant and machine operatives; and elementary occupations. Occupational differences for the economic activity outcome were most marked for the sick/disabled category. Policies to improve the health of local populations may support retention and reduce occupational inequalities in employment rates of older workers.

▶ Why and how do workplaces invest in mental health and wellbeing? A systematic review and process tracing study

HENSTOCK, L., JOHNSON, R., KINGHORN, P., *et al.*

2024

Social Science & Medicine 366: 117633.

https://doi.org/10.1016/j.socscimed.2024.117633

In recent years, investment in workplace mental health and wellbeing has grown. However, there is little understanding of how resource allocation decisions are made in such settings. To ensure evaluative research can support resource allocation, a process-based understanding of decision-making would be helpful. In phase one a systematic review of the literature on the implementation of workplace mental health and wellbeing schemes was conducted to draw insights on workplace resource allocation processes. In phase two an in-depth case study of a large company was conducted with interviews with those involved in resource allocation and wellbeing. Interviews were coded and analysed using descriptive and explanatory accounts. The findings from the review and case study were combined and developed into a causal process theory. This study shows that the stages in mental health and wellbeing investment revolve around ensuring organisational buy-in, workforce investment, and continual evaluation. Further work is needed to explore the transferability of the resulting process theory across different types of workplaces. However, it is clear that the features of real world decision-making in workplaces present challenges and opportunities for the research community.

▶ Employment shocks and demand for pain medication: Understanding the channels that drive opioid use

MUSSE, I.

2025

Health Economics 34(2): 316-344.

https://doi.org/10.1002/hec.4901

Abstract Higher employment ratios can affect opioid use through two main channels: by increasing physical pain from working or by reducing mental distress that may contribute to substance misuse. To separate these channels, I contrast the effect of labor demand shocks on the use of opioids with the effect on the use of over-the-counter painkillers—commonly used to treat pain but not mental distress. I find that during local economic expansions, opioid use declines while the demand for over-the-counter pain relief medication increases. Employment changes in high injury industries accentuate this pattern. One possible explanation is that, during local economic expansions, the use of pain medications to manage work injuries increases while the misuse of opioids decreases.

▶ Engaging Low-Wage Workers in Health and Well-Being Survey Research: Strategies From 5 Occupational Studies

SABBATH, E. L., LOVEJOY, M., SCHNEIDER, D. K., *et al.*

2025

American Journal of Public Health 115(2): 201-208.

https://doi.org/10.2105/AJPH.2024.307875

Without perspectives of low-wage workers in studies of worker health and well-being, researchers cannot comprehensively assess occupational health and health equity impacts of workplace exposures and interventions. Researchers and practitioners have noted particular challenges in engaging low-wage workers in worksite-based health survey research, yet little scholarship has described strategies for improving their engagement and response rates. To fill this gap, we present case examples from 5 occupational studies conducted between 2020 and 2024 in industries including health care, food service, and fulfillment centers. For each case, we describe how we identified barriers to worker engagement in surveys, explain specific strategies we used to address those barriers, and assess the effectiveness of these actions. Then, summarizing across case examples, we offer practical recommendations to researchers surveying low-wage populations, highlighting that high-touch recruitment, building trust with workers and managers, and obtaining manager support to take surveys during work time (for worksite-based studies) are critical for obtaining reliable, representative data. Our work contributes to broader discussions on improving survey response rates in vulnerable worker populations and aims to support future researchers undertaking similar efforts.

▶ Using citizen science to explore barriers and facilitators for healthy and sustainable lifestyles in office environments

ULLBERG, O. H., TOIVANEN, S., KING, A. C., *et al.*

2024

Health & Place 90: 103377.

https://doi.org/10.1016/j.healthplace.2024.103377

The socio ecological model states that individual behaviors at work are shaped by the interactions between individual employees and their work environments. This study used citizen science to gain insights into which elements of the built, social, and organizational environment in an office and surrounding neighborhoods in two Swedish cities were perceived as barriers to or facilitators of healthy and sustainable behaviors at work. Participants in the eight-week Sustainable Office Intervention pilot study (SOFIA) (n = 33) were cluster-randomized into an experimental arm (sustainable lifestyle) or a control intervention arm (healthy lifestyle). They used the Our Voice Healthy Neighborhood Discovery Tool mobile app to document contextual elements at their workplaces. In total, 114 photos and text-based narratives were recorded, and four themes emerged: built environment, building design, office ergonomics, and food and beverages. Eighteen percent of the photos were linked to pro-environmental behaviors, all exclusively captured by the experimental arm. Twelve barriers and solutions for improving the workplace environment were identified during discussions with participants in both arms. The findings provide insights for designing or renovating office spaces and urban planning to promote healthier and more sustainable lifestyles for office workers.

Vieillissement

Aging

Mental health impacts of spousal caregiving intensity in the US

AILSHIRE, J. A. ET CASANOVA, M.

2025

Health Economics 34(2): 267-282

https://doi.org/10.1002/hec.4908

Abstract In the US, spouses are a major source of informal care for older adults and, therefore, key to the US national strategy to provide long-term care to the growing population of older adults. Understanding the mental health impacts of spousal caregiving is therefore critically important. Existing studies on the topic have often been limited by methodological limitations, and most overlook the role of caregiving intensity. In this study, we assess the impact of providing different intensities of caregiving to a spouse on mental health outcomes using data from the Health and Retirement Study. We address the endogeneity of the decision to provide different caregiving intensities using an augmented inverse probability weighted (AIPW) estimator adapted to handle multivalued treatments. We check the robustness of our estimates to the AIPW's identifying assumptions by re-estimating the model using a dynamic fixed effects estimator. We find strong evidence that becoming a caregiver is associated with worsened mental health outcomes for women, while the evidence for men is weaker. When disaggregating by caregiving intensity, we find that transitions into high-intensity caregiving lead to large increases in depression symptoms and the probability of exhibiting major depression for both men and women. The overall mental health impact of transiting into caregiving is driven almost exclusively by the negative impact of high-intensity caregiving, as transitions into low- and moderate-intensity caregiving are not associated with worsening mental health in most specifications. This study provides timely insights that can inform the targeting of long-term care policies and programs aimed at supporting family caregivers of older adults.

Aides formelles et informelles pour les seniors : substituabilité ou complémentarité ?

BONNAL, L., FAVARD, P. ET MAURICE, T.

2024

Revue économique 75(5): 897-943.

https://shs.cairn.info/revue-economique-2024-5-page-897

À partir des données de la vague 8 de l'enquête SHARE (Survey on Health, Ageing and Retirement), nous étudions l'utilisation des aides à domicile par les personnes âgées en Europe. Ces aides peuvent être utilisées par une personne âgée parce qu'elle est dans l'incapacité d'accomplir certaines tâches domestiques ou personnelles. Nous estimons simultanément les probabilités de recevoir de l'aide formelle et informelle et le nombre d'heures d'aide formelle reçues, en tenant compte des interactions réciproques entre les aides. Nous montrons que la relation est très significativement négative, mais cela n'est pas suffisant pour en conclure que l'aide formelle est un substitut de l'aide informelle puisque ces aides sont une agrégation de services rendus hétérogènes. Nous conduisons une étude différenciée suivant que l'aide est domestique ou personnelle. En considérant des services plus homogènes la substituabilité est très significativement établie. Classification JEL : C35, I1, J14.

Projected costs of long-term care for older people in England: The impacts of housing quality improvements

HU, B., BRIMBLECOMBE, N., CARTAGENA-FARIAS, J., *et al.*

2025

Health Policy 152: 105246.

https://www.sciencedirect.com/science/article/pii/S0168851025000028

Good quality housing is vitally important to public health. However, its economic consequences for the long-term care sector and implications for health policy have not been thoroughly examined. This study investigates the impacts of housing improvements on future costs of long-term care in England. Using data from two national surveys, the English Longitudinal Study of Ageing (ELSA) and the Health Survey for England

(HSE), we combined a Markov model with a macrosimulation model to make projections of long-term care costs under a series of housing intervention scenarios. We project that, without housing interventions, formal care costs will increase from £22.4 billion to £40.8 billion and unpaid/informal care costs will increase from £55.2 billion to £90.8 billion between 2022 and 2042. In a scenario where all housing problems are remedied, formal and unpaid care costs in 2042 are projected to be £2.8 billion and £7.1 billion lower than the no intervention scenario, respectively. There are substantial synergies between health and housing policies. Well-designed housing improvement programmes delay the progression of long-term care needs, resulting in lower long-term care costs. The cumulative savings of long-term care costs over time can pay back the investment needed for housing improvements.

▶ Comparison of Caregiver and General Population Preferences for Dependency-Related Health States

RODRÍGUEZ-MÍGUEZ, E. ET SAMPAYO, A.

2025

Applied Health Economics and Health Policy 23(1): 105-117.

https://doi.org/10.1007/s40258-024-00908-x

We assess whether the preferences regarding dependency-related health states as stated by informal caregivers are aligned with those expressed by the general population.

▶ Association between frailty and subsequent disability trajectories among older adults: a growth curve longitudinal analysis from the Survey of Health, Ageing and Retirement in Europe (2004–19)

WOLDEMARIAM, S., OBERNDORFER, M., STEIN, V. K., *et al.*

2024

European Journal of Public Health 34(6): 1184-1191.

https://doi.org/10.1093/eurpub/ckae146

Frailty is associated with adverse health outcomes in ageing populations, yet its long-term effect on the development of disability is not well defined. The study examines to what extent frailty affects disability trajectories over 15 years in older adults aged 50+. Using seven waves of data from the Survey of Health, Ageing and Retirement in Europe (SHARE), the study estimates the effect of baseline frailty on subsequent disability trajectories by multilevel growth curve models. The sample included 94 360 individuals from 28 European countries. Baseline frailty was assessed at baseline, using the sex-specific SHARE-Frailty-Instrument (SHARE-FI), including weight loss, exhaustion, muscle weakness, slowness, and low physical activity. Disability outcomes were the sum score of limitations in activities of daily living (ADL) and Instrumental ADL (IADL). Analyses were stratified by sex. Over 15 years, baseline frailty score was positively associated with disability trajectories in men [βADL = 0.074, 95% confidence interval (CI) = 0.064; P = .083; βIADL = 0.094, 95% CI = 0.080; P = 0.107] and women (βADL = 0.097, 95% CI = 0.089; P = .105; βIADL = 0.108, 95% CI = 0.097; P = .118). Frail participants showed higher ADL and IADL disability levels, independent of baseline disability, compared with prefrail and robust participants across all age groups. Overall, participants displayed higher levels of IADL disability than ADL disability. Study findings indicate the importance of early frailty assessment using the SHARE-FI in individuals 50 and older as it provides valuable insight into future disability outcomes.

▶ Unpacking the care-related quality of life effect of England's publicly funded adult social care. A panel data analysis

SALAS-ORTIZ, A., LONGO, F., CLAXTON, K., *et al.*

2025

Health Economics 34(2) : 246-266

https://doi.org/10.1002/hec.4907

Abstract Adult Social Care (ASC) is the publicly-funded long-term care program in England that provides support with activities of daily living to people experiencing mental and/or physical challenges. Existing evidence suggests that ASC expenditure improves service users' care-related quality of life (CRQoL). However, less is known about the channels through which this effect exists and the effect on outcomes other than CRQoL. We fill this gap by analyzing survey data on ASC service users who received long-term support from 2014/15 to 2019/20 using panel data instrumental variable methods. We find that the beneficial impact of ASC expenditure on the CRQoL of both new and existing users is mostly driven by users aged 18–64 without any learning disability and users with no learning disability aged 65 or older receiving community-based ASC. Moreover, control over daily life, occupation, and social participation are the CRQoL domains that are improved the most. We also find that ASC expenditure has a beneficial effect on several other outcomes beyond CRQoL for both new and existing users including user satisfaction and experience, the ability to carry out activities of daily living independently, whether their home is designed around needs, accessibility to local places, general health, and mental health through reduced anxiety and depression. Greater ASC expenditure, however, does not address the need for other forms of support such as unpaid informal and privately-funded care.

▶ Spousal Characteristics and Unmet Care Needs: A Longitudinal National Study of Adults Aged 50 and over in England

ZHANG, J., BENNETT, M. ET ZHANG, Y.

2024

Social Science & Medicine 365: 117530.

https://doi.org/10.1016/j.socscimed.2024.117530

This paper investigates unmet needs among dyads of people aged 50 and over in England. Understanding the extent and patterns of unmet needs for long-term care across different social groups is critical for understanding care-related experiences and inequalities and planning the long-term care system. Although spouses are a main source of care support, little is known about how spouses' characteristics relate to one's experience of unmet care needs. This study adopts a dyadic perspective, investigating the association between unmet care needs and spouses' characteristics, including socioeconomic status, health status and the quality of spousal relationships. Drawing on data from the English Longitudinal Study of Ageing (ELSA) (N=3,439), we matched the information of individuals who have care needs to the characteristics of their spouses and used random effects modelling to account for the longitudinal nature of the data. The results show that having a spouse with poorer functional abilities was associated with a higher risk of experiencing objective and subjective unmet needs. Men were more likely to experience objective unmet care needs if their spouses engaged in paid work, but this is not the case for women. Women faced a lower risk of subjective and objective unmet needs when having a closer relationship with their spouse, whereas this pattern was not observed among men. The findings highlight the importance of considering the interpersonal care relationships and gendered dynamics of caregiving, providing insights into designing gender-sensitive intervention programmes to better support people in care needs and their families.

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