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

Octobre 2025 / October 2025

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

Présentation

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

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

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

Presentation

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

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

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

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

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

Veille scientifique en économie de la santé / **Watch on Health Economics Literature**

Directeur de la publication	Denis Raynaud	Publication Director
Documentalistes	Véronique Suhard Rouguiyatou Ndoye	Information specialists
Maquette & Mise en pages	Franck-S. Clérembault Damien Le Torrec	Design & Layout

ISSN : 2556-2827

Institut de recherche et documentation en économie de la santé
21-23 rue des Ardennes - 75019 Paris • Tél. : 01 53 93 43 00 • www.irdes.fr

Sommaire
Contents

Assurance maladie
Health Insurance

Démographie
Demography

E-santé
E-Health

Economie de la santé
Health Economics

Environnement et santé
Environmental Health

État de santé
Health Status

Géographie de la santé
Geography of Health

Handicap
Disability

Hôpital
Hospital

Inégalités de santé
Health inequalities

Médicaments
Pharmaceuticals

Méthodologie - Statistique
Methodology-Statistics

Politique de santé
Health Policy

Politique sociale
Social Policy

Prévention
Prevention

Psychiatrie
Psychiatry

Sociologie de la santé
Sociology of Health

Soins de santé primaire
Primary Health Care

Travail et santé
Occupational Health

Vieillissement
Ageing

Assurance maladie

Health Insurance

Medicaid Expansion Among Nonelderly Adults and Cardiovascular Disease: Efficiency Vs. Equity

BARRY, L. E., BASU, S., WANG, M., *et al.*

2025

The Milbank Quarterly 103(2): 390-439.

https://doi.org/10.1111/1468-0009.70004

Policy Points Evidence suggests Medicaid expansion has improved cardiovascular disease (CVD) outcomes, especially among those of lower socioeconomic status. However, less is known about the cost-effectiveness of Medicaid in achieving these outcomes and reducing CVD disparities. We found that Medicaid expansion resulted in a reduction in CVD incidence, suggesting that it was cost-effective in reducing CVD outcomes and equity enhancing but with a high degree of uncertainty. Policymakers will need to trade-off among a number of different factors in consideration of the value of Medicaid including health (especially in treating the chronically ill), financial protection, reduced uncompensated care, and health disparities. Context Evidence suggests Medicaid expansion has improved cardiovascular disease (CVD) outcomes, especially among those of lower socioeconomic status. However, less is known about the cost-effectiveness of Medicaid in achieving these outcomes and reducing CVD disparities. We use distributional cost-effectiveness analysis methods to examine the efficiency and equitability of Medicaid expansion in reducing CVD outcomes. Methods A Monte Carlo Markov-chain microsimulation model was developed to examine lifetime changes in CVD outcomes and disparities as a result of expansion and the associated cost and quality-of-life impacts. Findings Medicaid expansion was associated with a reduction of 11 myocardial infarctions, eight strokes, and four CVD deaths per 100,000 person-years compared with no expansion. The largest reductions occurred for those with lower income and education, and those of Black and Hispanic race/ethnicity. We found that the benefits of expansion generally balanced out the costs while redistributing health from higher to lower income groups. In probabilistic sensitivity analysis, we found—using a health opportunity cost threshold of $150,000—that Medicaid expansion was cost-effective in reducing CVD outcomes 53% of the time and both cost-effective (efficient) and equity enhancing 26% to 29% of the time. Conclusions Medicaid expansion resulted in a reduction in CVD incidence, suggesting that it was both cost-effective and equity enhancing in reducing CVD outcomes but with a high degree of uncertainty.

Consequences of Medicare Advantage for Beneficiaries and Politics: Revisiting The Delegated Welfare State

CAMPBELL, A. L. ET MORGAN, K. J.

2025

Journal of Health Politics, Policy and Law 50(4): 629-657.

https://doi.org/10.1215/03616878-11825370

The Delegated Welfare State (Morgan and Campbell 2011) explored the causes and possible consequences of the 2003 Medicare reform boosting private managed care plans in the delivery of Medicare benefits. In this article, the authors review scholarship on beneficiary experience (access, costs, outcomes) and political feedbacks arising from the delegated governance reform to evaluate whether predictions about consumer behavior and policy entrenchment have come true. They find that beneficiary experiences and satisfaction do not differ significantly between Medicare Advantage (MA) and traditional Medicare, and MA plans' managed care techniques have cut per-beneficiary spending. But MA remains costlier to the federal government per beneficiary because of the outsized payments received by plan providers. Officials have failed to rectify these overpayments because of policy feedback effects, that is, the empowerment of lobbying groups with a stake in the program and beneficiary support for it. Growing dependence on private plans to deliver health insurance for senior citizens, a large and politically influential constituency, has rendered government officials and elected politicians reluctant to imperil this market and the happiness of beneficiaries.

Employment, Income, the ACA, and Health Insurance Coverage of Working-Age Adults During the First Year of the COVID-19 Pandemic: A Reassessment

ESCARCE, J. J., RUNGER, D., CAMPBELL, J. M., *et al.*

2025

Health Services Research n/a(n/a): e14646.

https://doi.org/10.1111/1475-6773.14646

ABSTRACT Objective To examine the effects of income, income transitions, and the Affordable Care Act (ACA) Medicaid expansion on health insurance coverage for working-age adults who became unemployed during the first year of the COVID-19 pandemic and for those who remained employed. Study Setting and Design We estimated panel-data regression models to assess the effects of employment, income and income transitions, and the Medicaid expansion on the type of insurance coverage and uninsurance among working-age adults in the United States during 2019 and 2020. Data Sources and Analytic Sample Longitudinal data from the 2019–2020 Medical Expenditure Panel Survey and data on states' Medicaid expansion status. The study participants were 6435 adults aged 26–64. Principal Findings Participants in all income groups who suffered spells of unemployment during the pandemic lost employer-sponsored insurance. In expansion states, the Medicaid expansion played a key role in preventing declines in insurance coverage for disadvantaged participants. The expansion was especially beneficial for participants with low pre-pandemic incomes who had unemployment spells during the pandemic (7.5% point increase in Medicaid coverage [95% CI, 1.2 to 13.8]) and for participants who transitioned from high pre-pandemic incomes to low pandemic incomes whether or not they lost their jobs (23.9% point increase in Medicaid coverage [95% CI, 7.8 to 40.0] during unemployment spells; 12.0% point increase [95% CI, 7.2 to 16.9] for those who remained employed). We found weaker evidence that private exchange coverage blunted increases in uninsurance in non-expansion states. Conclusion Our findings clarify findings from earlier research by demonstrating that not only employment status and pre-pandemic income, but also income transitions, played a key role in determining who received Medicaid coverage during the pandemic in Medicaid expansion states. All in all, the ACA acquitted itself relatively well during a very stressful period for the United States' system of health insurance.

Behavioral Responses to Healthcare Funding Decisions and Their Impact on Value for Money: Evidence From Australia

GHIJBEN, P., PETRIE, D., ZAVARSEK, S., *et al.*

2025

Health Econ 34(7): 1239-1254.

https://doi.org/10.1002/hec.4958

Value for money is fundamental to health insurance schemes given insurers must choose which treatments to fund. Assessing value for money ex ante is challenging, however, because costs and outcomes depend on how treatments are used. Estimates often rely on evidence from early randomized controlled trials conducted prior to regulatory approval, where provider and patient behaviors are tightly controlled. This approach ignores how different supply conditions and incentives in practice influence behaviors. This paper considers how provider and patient incentives can differ between trial and practice settings and analyses how healthcare use changed when new prostate cancer treatments were funded on the public health insurance scheme in Australia. We find evidence that doctors treated patients with worse prognosis compared to the trials, patients ceased prior treatment and switched to the new treatments earlier than expected, and treatment duration was longer than expected. These and other behavioral responses reduced value for money ex post. Our findings suggest that health insurers should carefully consider the supply conditions and incentives in practice when funding new treatments.

The Evolution of Medicare: Challenges, Responses, and Prospects

GLIED, S., FRANK, R. ET LUI, B.

2025

Journal of Health Politics, Policy and Law 50(4): 603-628.

https://doi.org/10.1215/03616878-11830274

The Medicare program has provided a near-universal source of health care coverage for America's elderly since 1965. Over its 60-year history, the program has evolved to cover a greater share of the population and to pay for an increasing share of the nation's health care bills. As Medicare has grown, so too have its challenges. The traditional Medicare program has failed to keep pace with a rapidly changing health care sector and demographic shifts. Constrained by its own benefit design, Medicare has allowed privately con-

tracted health plans (Medigap, Medicare Advantage) to provide much needed yet inadequate remedies to the program's shortcomings. After briefly recounting Medicare's origins, we discuss how the program's founding statutes have hindered its ability to respond to new and growing challenges along the dimensions of cost sharing, cost containment, and benefit design. We then propose a three-pronged approach to reforming Medicare's benefit structure. We argue that a simplified enrollment process, a single benefit that brings together the program's constituent parts (Part A, Part B, and Part D), and a new organizational structure for care delivery based on the program's experience with Accountable Care Organizations will together create a robust foundation that can sustain the Medicare program into the future.

▶ A change of plans: Switching costs in the procurement of health insurance

POLITZER, E.

2025

Journal of Health Economics 102: 103021.

https://doi.org/10.1016/j.jhealeco.2025.103021

The provision of public health insurance through regulated markets requires a dynamic procurement of insurers over time. Using data from Medicaid managed care bids, I study the impacts of regulators' decision to drop an insurer from the market on health care use among affected enrollees, who must switch to another health plan. Using a difference-in-differences framework, I find that after a plan is replaced, enrollees from the exiting plan have fewer visits to primary care physicians, lower utilization of prescription drugs, including those for chronic conditions, and more hospital admissions. These disruptions disproportionately affect sicker enrollees, particularly children and non-white beneficiaries. In the year following the exit, insurers' spending on enrollees from exiting plans is 7% lower than the pre-exit baseline. Changes in provider networks and drug formularies may serve as mechanisms.

▶ A new integrated conceptual framework of health insurance literacy: Results of a critical interpretive synthesis

RON, R., FEDER-BUBIS, P., TROCHA, K., *et al.*

2025

Health Policy: 161 : 105394.

https://doi.org/10.1016/j.healthpol.2025.105394

Health insurance literacy (HIL) is the knowledge, ability, and confidence to find and understand health insurance information, and choose, purchase and use an insurance plan. Despite the increasing volume of research on HIL, the approaches to this field remain fragmented. This review paper aims to develop a conceptual framework delineating the attributes, personal contexts, and environmental influences, which either influence or are influenced by an individual's HIL level. We have adopted a critical interpretive synthesis approach with purposive sampling and inductive analysis, integrating all existing models from the literature, with additional findings. The CIS methodology emphasizes iterative data synthesis to generate theory from diverse sources, ceasing data extraction upon achieving theoretical saturation. This reflects the stage at which further data collection no longer yields new conceptual insights. Four databases were systematically screened in September 2020 and July 2023, yielding 6,096 articles. Following a review of titles and abstracts, 388 papers were deemed relevant, and 76 were included in the final synthesis. The resulting framework consists of eight categories, 17 subcategories, and 129 codes, with HIL level as its core. Other components include individual predictors, external influences, skills and abilities, perceptions and beliefs, preferences, decision-making processes, and outcomes. This framework provides a comprehensive tool for guiding interventions and research aimed at improving HIL. It allows researchers and policymakers to address the diverse and interconnected factors influencing HIL and to develop targeted, evidence-based strategies.

▶ The Shadow Price of Uncertainty: Consequences of Unpredictable Insurance Coverage for Access, Care, and Financial Security

SCHLESINGER, M. ET BHAUMIK, D.

2025

The Milbank Quarterly 103(2): 440-479.

https://doi.org/10.1111/1468-0009.70006

Policy Points Health insurance reform in the United States has fostered enrollment to promote access to care and reduce financial insecurity. However, enrollees' inability to reliably predict what insurance will cover (a.k.a. "coverage uncertainty") impedes these goals, often as much as being uninsured. The Patient Protection and Affordable Care Act initially expanded enrollment and reduced coverage uncertainty. After the mid-2010s, trends in coverage uncertainty plateaued,

and it now impedes access to care for four times as many households as lack of health insurance. A variety of policies can moderate coverage uncertainty, but other popular reform strategies exacerbate it instead. Our findings suggest that structural reforms represent the most promising remedial strategies, particularly those that can enhance support for households negotiating coverage denials with insurers. Context Health insurance reform in the United States has focused on expanding enrollment, a goal inhibited by complex insurance provisions. Research documents this complexity and shows how it increases consumers' challenges in anticipating needs and making informed choices, potentially deterring policy purchases. Little is known about how coverage uncertainty impacts those who have insurance. Methods Drawing on a multiwave survey with nationally representative data, we assessed consumer experiences and expectations in 2009, 2014, and 2021. Respondents identified (a) worries about the reliability of health insurance coverage, and (b) experiences of insurance not covering major medical expenses. Respondents also reported on three health care–related experiences—whether they delayed access to needed care, had been unable to effectively care for chronic health conditions, or felt anxious about future medical expenses. We estimated regressions associating metrics of coverage uncertainty with the three health care–related outcomes, controlling for socioeconomic status and other household characteristics. Findings Of American households, 32% reported intense worry about coverage reliability in 2009. This declined to 27% in 2014, then rebounded to 31% in 2021. Experiences of coverage shortfalls followed a similar pattern, declining from 27% to 17%, then rising back to 21%. Coverage uncertainty has statistically significant associations with all three outcomes, with access being the most sensitive to low-level uncertainty. By 2021, coverage uncertainty deterred timely access in care for one in five American households, five times as many as among the uninsured. Conclusions Coverage uncertainty has become the predominant barrier to timely access. It also disrupts care for chronic conditions and exacerbates anxiety over medical expenses. These harms can be reduced. However, several popular health care reform strategies instead exacerbate coverage uncertainty. We explicate these overlooked cross-policy connections and identify alternative strategies that could moderate the impact of coverage uncertainty in the United States

▶ Who Enrolls in Coverage and Who Remains Uninsured? Medicaid Take-Up Before and After the Affordable Care Act and During Unwinding

SMITH, R. B., ABOULAFIA, G. ET SOMMERS, B. D.

2025

The Milbank Quarterly 103(2): 349-389.
https://doi.org/10.1111/1468-0009.70020

Policy Points The Affordable Care Act (ACA) dramatically expanded Medicaid eligibility in participating states. However, many eligible individuals remain uninsured because they do not enroll in (or "take up") coverage. The unwinding of the pandemic continuous enrollment provision in 2023-2024 further raised the importance of this issue. After the ACA, we found a significant increase in Medicaid take-up among eligible individuals across all eligibility pathways; these gains persisted into 2023, which coincided with the beginning of the unwinding. However, important vulnerabilities in enrollment are still apparent, including a steep drop-off in take-up when children become young adults and persistent lower take-up among childless adults and residents of nonexpansion states. These findings can guide policies in the postpandemic post-ACA era and suggest that efforts to reduce outreach or scale back the ACA will threaten coverage for many Medicaid beneficiaries. Context Many uninsured individuals in the United States are eligible for Medicaid but not enrolled. The Affordable Care Act (ACA) expanded Medicaid eligibility starting in 2014, streamlined enrollment, and boosted outreach. During the 2020 COVID-19 pandemic, states were required to provide continuous coverage to Medicaid enrollees, a policy that ended in April 2023, with resulting coverage losses during the "unwinding" of this policy. Methods Using household data from the American Community Survey and state-level eligibility criteria, we assessed Medicaid participation among US citizens younger than 65 years old who either had Medicaid coverage or no insurance. We compared results before the ACA (2008-2010), after the ACA (2017-2019), and during "unwinding" (2023). We utilized logistic regression to identify predictors of take-up in each of these time periods. Findings The national take-up rate among Medicaid-eligible individuals rose from 76.5% before the ACA to 85.0% after the ACA. These gains persisted in 2023 as unwinding began, when take-up was slightly higher (86.5%) than before the pandemic. Post-ACA participation was highest among eligible children; Asian American, Pacific Islander, and Native Hawaiian and Black individuals; and residents of expansion states. Participation was

lowest among adults ages 19-21 years old, American Indian and Alaska Native (AI/AN) individuals, employed adults, and those facing premiums for Medicaid coverage. Take-up improved post-ACA in both more and less deprived neighborhoods, whereas urban areas saw greater growth in take-up than rural areas. Conclusions From the pre- to post-ACA period, Medicaid take-up rates among eligible individuals increased, and these gains persisted during the beginning of the unwinding period, potentially reflecting increased outreach efforts under the Biden administration. However, areas of vulnerability remain among young adults, working adults, AI/AN individuals, and those in rural areas. These findings have important implications as the unwinding period ends, and large changes to Medicaid may be considered after the 2024 elections.

▶ The causal effects of mandatory health insurance coverage expansion in Switzerland

KAISER, B., KOHLER, A. ET SCHMID, C. P. R.

2025

International Journal of Health Economics and Management 25(2): 193-215.

https://doi.org/10.1007/s10754-025-09396-5

The expansion of public health insurance programs affects payers as well as the behavior of service providers. In this paper, we study the expansion of Swiss mandatory health insurance in 2012 to include complementary and alternative medicine physician services. The policy change provides a quasi-experimental design that allows us to estimate the causal effects on the payer and physician behavior using a difference-in-differences framework. First, we find that from the payer's perspective, expanding coverage to complementary and alternative medicine increases physician costs per patient by about 7 percent. Second, we find that the increase in physician service costs per patient in mandatory health insurance is almost exactly offset by a decrease in supplementary health insurance costs. Thus, suggesting that the behavior of physicians was unchanged by the coverage expansion.

Démographie

Demography

▶ Les Français·es veulent moins d'enfants

BOUCHET-VALAT, M. ET TOULEMON, L.

2025

Population & Sociétés n° 635(7)

https://doi.org/10.3917/popsoc.635.0001

▶ L'évolution démographique récente de la France : Une position singulière dans l'Union européenne

BRETON, D., BELLIOT, N., BARBIERI, M., *et al.*

2024

Population 7 79(4): 427-505.

https://doi.org/10.3917/popu.2404.0427

Au 1er janvier 2024, la France comptait 68,4 millions d'habitants, soit 230 000 de plus qu'au 1er janvier 2023. Le solde naturel a atteint un niveau historiquement bas depuis l'après-guerre et depuis 2018, et le solde migratoire est le principal moteur démographique du pays. Deuxième pays le plus peuplé de l'UE27 (15,2 % de la population), la France présente toutefois un accroissement légèrement inférieur à celui de la moyenne européenne et demeure un peu plus jeune que la moyenne de l'UE, mais vieillit plus rapidement. En 2022, les flux d'entrées de ressortissants de pays tiers ont augmenté et atteignent le niveau le plus élevé depuis 2000 (282 957 personnes). L'année 2022 est marquée par une augmentation conséquente de la part des flux pour raisons professionnelles (+ 4 points) et par une féminisation de ces derniers (+ 15 points). La France est le 5e pays de l'UE27 pour le flux migratoire, mais se trouve seulement en 21e position si l'on tient compte de la taille de la population. En 2023, la baisse historique du nombre de naissances est la conséquence de celle de la fécondité (1,67 enfant par femme), niveau le plus faible observé depuis l'après-guerre. La baisse concerne tous les groupes d'âges. Le profil de la fécondité par âge en France est proche de celui des pays

d'Europe de l'Ouest et du Nord, et la proportion de naissances hors mariage y est la plus élevée d'Europe (65,2 %). En 2023, le nombre d'avortements augmente pour la deuxième année consécutive, et 8 avortements sur 10 sont désormais médicamenteux. Quand on rapporte ce chiffre au nombre de femmes de 15 à 49 ans, la France enregistre, avec la Suède, le taux de recours à l'avortement le plus élevé d'Europe, mais c'est aussi un des pays où la réglementation est la moins restrictive. Le nombre de mariages augmente très légèrement en 2023, tout comme celui des pacs en 2022 (année la plus récente disponible), mais le rattrapage *post*-Covid n'est que partiel. La part des pacs et des mariages entre personnes de même sexe reste relativement stable en 2023 et, avec un âge moyen au mariage qui continue d'augmenter, la France se rapproche des pays du Sud et de l'Ouest de l'Europe, où le mariage est moins précoce que dans les pays de l'Est. En baisse depuis 3 ans, le nombre de décès reste plus élevé que celui observé avant la pandémie (2019). En revanche, l'espérance de vie en 2023 est supérieure à celle de 2019, pour les hommes comme pour les femmes, même si le rebond en France est inférieur à celui observé dans d'autres pays d'Europe. Comparée aux autres pays européens, la mortalité française reste relativement basse aux âges plus élevés, mais le pays montre un retard important et croissant pour la mortalité infantile. L'écart de mortalité entre les hommes et les femmes est plus élevé que dans la moyenne européenne, même s'il continue de baisser. Le cancer est la première cause de mortalité en France, alors qu'il s'agit des maladies cardiovasculaires à l'échelle européenne.

E-santé

E-Health

▶ Digital health literacy among the Spanish population: a descriptive and latent class analysis study

HERNÁNDEZ ENCUENTRA, E., GONZÁLEZ CABALLERO, J. L., MONTAGNI, I., *et al.*

2025

European Journal of Public Health 35(4): 617-623.

https://doi.org/10.1093/eurpub/ckaf016

Spain has been consolidating the implementation of digital healthcare. However, there is not a comprehensive picture of the digital health literacy of the population in relation to existing policies and practices. To identify different profiles of people by analysing their digital health literacy, with the ultimate goal of providing healthcare organizations with indications to improve the relationship between people and the healthcare system. This cross-sectional survey study included 400 people aged ≥18 years from May 2021 to May 2022 in Spain. Participants were stratified by gender, age range, and residential area mirroring the Spanish population, and were recruited by an online panel and in community settings. A self-administered online survey was used, including the eHLQ questionnaire as a main measure and sociodemographic information. The digital health literacy level was medium and balanced among the seven eHLQ dimensions (ranging from 2.60 to 2.77 out of 5). The latent class analysis revealed five profiles based on the scores of the dimensions of the eHLQ questionnaire and taking into account age, technology use, and educational level. Access to digital services that work, together with using digital technology to process health information, is the main challenge identified by the participants. National health institutions and policies should focus not only on educating and training in digital skills but also on providing reliable and useful digital health services. This is the first study to provide a comprehensive digital health literacy profile of the Spanish population using the eHLQ questionnaire.

▶ Overcoming medical overuse with AI assistance: An experimental investigation

WANG, Z., WEI, L. ET XUE, L.

2025

Journal of Health Economics 103: 103043.

https://doi.org/10.1016/j.jhealeco.2025.103043

This study examines the role of Artificial Intelligence (AI) in reducing medical overtreatment, a critical healthcare challenge that increases costs and patient risks. In two experiments –with 196 physicians at a hospital and

120 students at a medical school in Wuhan– we use a novel medical prescription task under three incentive schemes: flat (constant pay), progressive (pay increases with treatment quantity), and regressive (penalties for overtreatment) to estimate receptivity to AI assistance and its effects on overtreatment and treatment accuracy, and test whether effects vary with incentives. AI recommendation of a treatment is estimated to increase the probability a physician prescribes it by 25.7-28.4 percentage points (pp), with the largest effect under the flat scheme. Physicians are more receptive to AI recommendations in medical domains with which they are less familiar. We estimate that AI assistance reduces the probability a physician overtreats by 10.9-25.7 pp (15.2-80.3%), with significantly larger absolute and relative effects under the flat scheme compared to progressive and regressive schemes. AI assistance improves physicians' treatment accuracy by 9.8-13.3 pp (14.6-19.9%), with the largest absolute effect under the regressive scheme. These findings are corroborated by the medical school experiment, which reveals that factors indicative of insufficient ability account for 34% of the explained variation in overtreatment, monetary incentives account for 22%, patient welfare considerations account for 20%, and factors related to defensive medicine for 10%. These results provide valuable insights for healthcare administrators considering AI integration into healthcare systems.

▶ Operationalising Public Trust for Health Policymakers - A Qualitative Study in the EU, France, Italy, and Switzerland

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

2025

Health Policy 161: 105393.

https://doi.org/10.1016/j.healthpol.2025.105393

Background : Public trust is crucial for the success of health data-sharing initiatives (HDSIs), as it influences public participation. Although the potential for policies to actively foster trust is widely acknowledged, recent policy analyses suggest that this opportunity is often overlooked in practice. Objective To investigate if and how health policymakers at the European Union level and in France, Italy, and Switzerland prioritise and integrate public trust into their policy work, identifying key gaps and providing preliminary guidance to bridge them. Methods : We conducted 57 semi-structured online interviews with policymakers involved in HDSIs at different stages of the policy process: 20 at the European level, 11 in France, 13 in Italy, and 13 in Switzerland. An inductive thematic approach was employed to identify emerging themes. Results : Policymakers recognise public trust as crucial for public participation in HDSIs, yet no shared definition of trust in health data-sharing emerged. In France, trust-building is treated as a policy priority and embedded in stakeholder and public engagement processes prior to legislation. At the European, Italian, and Swiss levels, trust remains a vague concept, addressed implicitly without clear strategies. Policymakers highlighted the absence of specific guidance on trust-building and called for its development. Conclusions : We identified a lack of harmonisation among policymakers regarding the definition of public trust and its translation into policy. In response, we propose a working definition of public trust in health data-sharing and highlight the urgent need for concrete, actionable tools to support policymakers in integrating trust-building principles into health data-sharing policies.

Economie de la santé

Health Economics

▶ Investigating the Spillover Mechanisms of Payment Incentives on the Outcomes for Non-Targeted Patients

BRITTEON, P., KRISTENSEN, S. R., LAU, Y. S., *et al.*

2025

Health Econ 34(7): 1274-1294.

https://doi.org/10.1002/hec.4956

Payment reforms in healthcare can have spillover effects on the care experienced by non-targeted patients treated by the same provider. Few empirical studies have quantitatively investigated the mechanisms behind these effects. We formulate theory-driven hypotheses to investigate the spillover mechanisms

of a regional payment reform in the English National Health Service, using linked patient-physician data and difference-in-differences methods. We show that regional payment changes were associated with an increase in mortality of 0.321 percentage points (S.E. 0.114) for non-targeted emergency patients who were treated by physicians with no exposure to the incentives, compared to control regions. In contrast, the mortality rate for non-targeted patients reduced by 0.008 percentage points (S.E. 0.002) for every additional targeted patient treated per quarter by their physician. These findings were consistent across a range of sensitivity analyses. The findings suggest that providers diverted resources away from non-targeted patients but that patients benefitted from physicians learning from the incentives. We demonstrate how the formulation of theory-driven hypotheses about spillover mechanisms can improve the understanding of how and where spillover effects may occur, contributing to research design and policymaking.

▶ Toward Monitoring and Addressing the Commercial Determinants of Health: Where Can We Go From Here?

BURGESS, R., SREBOTNJAK, T., LIN, C., *et al.*

2025

Milbank Q 103(2): 254-315.

https://doi.org/10.1111/1468-0009.70012

Policy Points We describe ways to advance two key priorities related to the commercial determinants of health (CDH): the development of systems to monitor commercial practices and the creation of policy recommendations to address the CDH. Specifically, we discuss corporate nonfinancial reporting as a potential mechanism to obtain data on commercial practices that influence population health, describe the potential risks and benefits, and propose opportunities to advance high-quality corporate reporting on health impacts. We also review previous global agenda-setting exercises to suggest five key considerations to inform the World Health Organization's forthcoming policy recommendations for addressing the CDH.

▶ Fee-For-Service, Accountable Care Organizations, And Medicare Advantage: Why?

CHERNEW, M. E.

2025

Health Affairs 44(8): 920-924.

https://doi.org/10.1377/hlthaff.2025.00713

This Perspective discusses the fiscal challenge facing Medicare and how that challenge may be differentially met by fee-for-service, accountable care organization (ACO), and Medicare Advantage (MA) payment systems. The non-MA part of Medicare includes both fee-for-service and ACO payment systems and is sometimes referred to as traditional Medicare. Fee-for-service, although in need of reform, is inherently ill suited to improving the efficiency of care delivery. MA and ACOs offer more promise, but design issues related to MA payment policy and ACO program features have limited their ability to reduce program spending. In the case of MA, which is paid more by Medicare than would be spent if beneficiaries were in traditional Medicare, the core questions are how much value is created by the added benefits that higher payment helps finance, and what would be lost If MA payment were changed. In the case of ACOs, the key question is how program design can build on the demonstrated ability of some ACO models to provide care more efficiently and save money.

▶ Nonlinear reimbursement rules for preventive and curative medical care

CREMER, H. ET LOZACHMEUR, J. M.

2025

Journal of Health Economics 103: 103049.

https://doi.org/10.1016/j.jhealeco.2025.103049

This study examines nonlinear reimbursement rules for secondary preventive and therapeutic care. Individuals may be healthy or ill, with illness severity determining their ex post type. Preventive care is chosen beforehand, while curative care is decided after health status is known. In an ideal scenario where health status is observable, optimal insurance provides lump-sum payments unrelated to expenditures. However, when severity is unobservable (causing ex post moral hazard), this approach is not incentive-compatible. Instead, optimal insurance designs benefits that increase with both preventive and curative care, as higher expenditures reduce informational rents and align incentives. Preventive care, though chosen before illness occurs, affects incentive constraints due to two factors: (1) it is more effective for severely ill individuals, and (2) they have lower marginal utility of income, meaning preventive expenditures impact them less. These effects shape the optimal reimbursement structure.

Additionally, when individuals misperceive preventive care benefits, the main results hold, but an extra corrective (Pigouvian) term appears in the reimbursement formula to adjust for this misperception.

Lived experience of out-of-pocket costs of health care and medicines by people with chronic conditions and their families in Australia: a systematic review of the qualitative literature

DESBOROUGH, J., MASKELL-KNIGHT, C. ET WANG, S.
2025
Health Policy 158: 105359.
https://doi.org/10.1016/j.healthpol.2025.105359

Background Despite Australia's universal health insurance scheme, Medicare, out-of-pocket costs (OOPC) for health care comprises 14 % of total health expenditure. People with chronic conditions spend a greater proportion of their incomes on health care than people without a chronic condition. Objective To review the qualitative literature examining experiences of OOPC of out-of-hospital care by people with chronic conditions and to discuss this in relation to current Australian health policy. Methods Systematic review and narrative synthesis of the qualitative literature examining OOPC for people with chronic conditions in Australia. Search: Pubmed, CINAHL Complete, Cochrane Library, PsycINFO and EconLit databases from 1999 to 10th April 2025. Results 37 studies met the inclusion criteria. Reduced or lost employment due to ill-health led to income loss, aggravating the financial burden of health management. While many people were able to access bulk-billing general practitioners, challenges in affording upfront and copayments for medical and allied health consultations, and medication costs were reported. Cost was the greatest barrier to accessing dental care. Trade-offs were described between health management and meeting basic living needs, particularly for people who earned too much to qualify for government welfare payments. Conclusion While Australian health policies effectively reduce the financial burden of health care for many people, distinct challenges exist for groups ineligible for concessional thresholds. Future research to identify the priorities and preferences of people with chronic conditions can further inform policy to improve the equity of health financing in Australia.

State Health Care Cost Commissions: Their Priorities and How States' Political Leanings, Commercial Hospital Prices, and Medicaid Spending Predict Their Establishment

FULTON, B. D., ARNOLD, D. R., WOLF, J. M., *et al.*
2025
The Milbank Quarterly 103(2): 554-580.
https://doi.org/10.1111/1468-0009.70019

Policy Points States are concerned about rising health care spending, and this study identifies states that have established health care cost commissions and describes the political and economic factors associated with their establishment. As of August 2024, 17 states had established commissions to reduce the growth of health care spending using various methods, including setting spending growth targets. Politically Democratic states and those with higher commercial hospital prices and higher Medicaid spending were more likely to establish such commissions. Because federal health care reform is difficult to enact, states are enacting their own reforms, tailored to their needs and political feasibility. Context States are becoming increasingly concerned about rising health care spending because it crowds out budgets for education and other obligations and it burdens consumers, exposing them to medical debt and bankruptcies. This study identifies states that have established health care cost commissions (HCCCs), examines state-level political and economic factors associated with their establishment, and reports which of these states have also enacted health care competition-related laws that further equip these commissions. Methods To identify states with HCCCs and competition-related laws, we reviewed prior reports, supplemented by our own research on state websites and from organizations that track state-level legislative and executive activity in health care. We estimated a regression model to understand how political and economic factors are related to these commissions being established. Findings As of August 2024, 17 states had established HCCCs that aim to reduce the growth of health care costs using a variety of methods, such as collecting health care use and spending data and setting spending growth targets. States that lean politically Democratic were more likely to establish these commissions, particularly those states with higher commercial hospital prices or higher Medicaid spending as a share of the state budget, or both. States with HCCCs have also enacted competition-related laws but to varying degrees. Conclusions Because health care reform is difficult to enact at the federal level, many

states are enacting their own reforms, tailored to their needs and political feasibility with many establishing HCCCs to limit health care spending increases. Future research should study the impact of these commissions on health care spending that increases short-term spending yet moderates long-term spending, including the feasibility and impact of increased spending on primary care services as well as the impact of spending on new health care technologies.

National Health Expenditure Projections, 2024–33: Despite Insurance Coverage Declines, Health To Grow As Share Of GDP

KEEHAN, S. P., MADISON, A. J. ET POISAL, J. A.

2025

Health Affairs 44(7): 776-787.

https://doi.org/10.1377/hlthaff.2025.00545

National health expenditures are projected to have grown 8.2 percent in 2024 and to increase 7.1 percent in 2025, reflecting continued strong growth in the use of health care services and goods. During the period 2026–27, health spending growth is expected to average 5.6 percent, partly because of a decrease in the share of the population with health insurance (related to the expiration of temporarily enhanced Marketplace premium tax credits in the Inflation Reduction Act of 2022) and partly because of an anticipated slowdown in utilization growth from recent highs. Each year for the full 2024–33 projection period, national health care expenditure growth (averaging 5.8 percent) is expected to outpace that for the gross domestic product (GDP; averaging 4.3 percent) and to result in a health share of GDP that reaches 20.3 percent by 2033 (up from 17.6 percent in 2023).

The Spillover Effects of a City-Wide Global Budget and Case-Based Payment Reform on Inbound Non-Resident Patients

JIANG, Y.

2025

Health Economics 34(9): 1663-1678.

https://doi.org/10.1002/hec.4979

ABSTRACT This study investigates the spillover effects of a city-wide global budget and case-based payment reform (known as the DIP reform) on non-resident patients from another city in the same province. By developing a theoretical model, I hypothesize that nontrivial deviation costs from reform-driven standard patient journeys could lead to reduced charges for patients who seek care in the reform city but are not subject to its payment reform policies. To test this hypothesis, I employ a difference-in-differences approach using discharge records to compare outcomes between patients from a non-reform outbound city hospitalized in the reform city, where DIP was implemented, and those hospitalized in other non-reform cities within the same province. The results indicate that the DIP reform significantly reduced total hospital charges for non-resident patients, without compromising care quality as measured by readmission rates. Notably, high-cost hospitals experienced more pronounced charge reductions compared to low-cost hospitals, highlighting the need to manage heterogeneous impacts on different healthcare providers to ensure equitable healthcare delivery.

Exploring social influences on healthcare user decision-making

NOUWENS, S. P. H., VELDWIJK, J., PILLI, L., *et al.*

2025

Social Science & Medicine 383: 118480.

https://doi.org/10.1016/j.socscimed.2025.118480

Commonly used choice models in healthcare assume that decision-making is an individualistic process, while other individuals or groups (i.e., influencers) can in fact impact decision-making. The purpose of this study is to examine different ways in which influencers affect healthcare user decision-making as an important step towards improving these choice models in healthcare. Two focus groups (n=12) and 41 semi-structured interviews were conducted, within a range of healthcare domains: influenza vaccination, birth care, joint replacement and prostate cancer treatment domains. Both healthcare users and physicians were interviewed. Participants were recruited through collaborations with a GP, hospital and a research panel. Data were analyzed with a grounded theory approach. Results reveal three main elements of decision-making which were affected by different social influence mechanisms. In the information-gathering phase the perception of alternatives, attribute levels and risks was influenced by information retrieved from someone in the social network, others' experiences, and social norms. In the preference formation phase, the relative importance of attributes and the value of alternatives were impacted by social norms, advice, and consideration of an influencer's stake in the decision. Finally, the process of actual decision-making could be more

deliberation-based or intuition-based through discussion with or consultation of others. The exact strength and impact of these influences differed per healthcare domain. This study provides further insights into social influences on healthcare user decision-making across multiple healthcare domains and provides comparisons between these domains. Several connections between influencers, social influence mechanisms and choice constructs were identified. These findings can help choice modelers develop models that more accurately reflect the decision-making process in health.

Private equity investment in long-term care: the case of Ireland

O'NEILL, N. ET MERCILLE, J.

2025

Health Policy 159: 105378.
https://doi.org/10.1016/j.healthpol.2025.105378

Background Private equity (PE) firms are key actors in the financialisation of health care systems. Yet, research rarely focuses directly on these firms and related private for-profit actors involved in financialisation. Moreover, existing work mostly concerns the United States, while several key health care sectors remain under-researched. Objective This study examines the factors driving PE investment in long-term care (LTC) and the strategies PE firms use to enter and expand within the sector. Methods We conduct a thematic analysis of 20 in-depth interviews with expert informants, including senior executives from PE firms, financial investors and private for-profit providers. These interviews shed light on the role of PE in Ireland's LTC sector, specifically within nursing homes and home care. Results Five key factors attract PE investment in Irish LTC: demographic trends, market composition, risk diversification, and the characteristics of state funding and regulation. In nursing homes, PE uses the "OpCo/PropCo" (operating company/property company) model. In home care, PE enters via global investments in parent companies, direct acquisitions of Irish firms, and master franchise agreements. Conclusions Examining private for-profit actors through key officials central to PE growth in LTC provides valuable insights into the financialisation of health care systems. This approach enhances our understanding of business interests driving investment in European LTC.

Exploring the Economic Burden of Pulmonary Arterial Hypertension and Its Relation to Disease Severity and Treatment Escalation: A Systematic Literature Review

RAMANI, G., BALI, V., BLACK, H., *et al.*

2025

PharmacoEconomics 43(7): 741-760.
https://doi.org/10.1007/s40273-025-01492-1

Pulmonary arterial hypertension (PAH) is a highly progressive disease characterized by luminal narrowing of the pulmonary arteries, leading to progressive dyspnoea and restricted functional capacity, which can ultimately result in right ventricular failure and death. Treatment goals include improving functional class and walk distance, recovering right ventricular function, halting disease progression, and improving survival. PAH carries a high mortality rate, and treatment escalation is a common feature of disease management. Due to the substantial impact of PAH, a high economic burden has been observed. A systematic literature review (SLR) was carried out to assess the contemporary economic burden of PAH, including the impact of disease severity and treatment escalation.

A Policy and Regulatory Framework to Promote Care Delivery Redesign and Production Efficiency in Health Care Markets

SCANLON, D. P., HARVEY, J. B., DAMBERG, C. L., *et al.*

2025

The Milbank Quarterly 103(2): 316-348.
https://doi.org/10.1111/1468-0009.70016

Policy Points Antitrust enforcement has been too narrowly focused on predicting postmerger market share and not enough on the likely impact of mergers and acquisitions on production efficiency and quality. Care delivery redesign is a term that captures various innovations and changes in the organization and delivery of health care, which may lead to increased production efficiency and improved quality of care. Regulators and policymakers can use the framework to develop empirical measures to assist in understanding changes in production processes as well as in resultant outcomes. Significant opportunities exist to improve data collection and require reporting to better assist regulators with antitrust enforcement and help policymakers create effective legislation. Examples include improving compliance with required hospital and insurer trans-

action price data reporting, growing the availability of all-payer claims databases, improving existing Medicare cost reporting, and achieving consensus on quality measures that are best used to measure the impact of consolidation. There is a fundamental need to systematically track health care organizations and their affiliations and component parts (e.g., hospitals, physician practices, skilled nursing facilities, etc.) longitudinally, especially as organizations expand across markets and state boundaries and are owned by various entities, including private equity.

Catastrophic and impoverishing out-of-pocket payments for health care in Poland in 2013–2021

TAMBOR, M., GARCIA-RAMIREZ, J. A. ET PAVLOVA, M.

2025

Health Policy OPEN 9: 100143.

https://doi.org/10.1016/j.hpopen.2025.100143

Protecting households from financial hardship when accessing health care is a universal policy objective across European countries. Previous analyses have shown that households in Poland relatively often experience financial strain due to out-of-pocket payments for health. This study aims to provide new evidence on financial protection in Poland, using indicators of catastrophic and impoverishing health spending. We used data from annual household budget surveys between 2013 and 2021. Catastrophic spending is defined as payments for health greater than 40% of the household's capacity to pay, while impoverishing spending occurs when out-of-pocket payments are higher than the capacity to pay. We employed logistic regression to identify factors associated with catastrophic payments. The incidence of catastrophic spending was 9% in 2021 and remained relatively constant over the years analyzed, nearing 10% only in 2020. Further, 3.3% of households in 2021 were impoverished or further impoverished, down from 4.1% in 2013. Payments for medicines contribute the most to catastrophic spending, but the role of other services has been increasing. We found a significant association between catastrophic payments and gender, age, education, disability, residence place, number of children, main source of income, and consumption level. It is necessary to address existing coverage gaps and to evaluate implemented policies in order to develop more effective measures to reduce the burden of out-of-pocket payments in Poland.

The Progressivity of Health Care Revenue Financing in 29 Countries: A Comparison

VÕRK, A., PAŽITNÝ, P., WAITZBERG, R., *et al.*

2025

Health Policy 159: 105381.

https://doi.org/10.1016/j.healthpol.2025.105381

Background This study assesses progressivity in public and private health care revenue collection among 29 high-income countries by combining the results of two previous articles comprising this special section of Health Policy. In those studies, we developed qualitatively based scores regarding revenue collection policies for three public revenue sources (income taxes, social insurance contributions, consumption taxes) and two private revenue sources (voluntary health insurance, out-of-pocket payments). Objective The current study sums these scores, weighted by the shares of each revenue source in each country, to calculate an overall progressivity score for each country. Methods We derived weights for each revenue source using publicly available OECD and Eurostat macrolevel data on the structure of health care financing and government revenues. Results France was the country that had the most progressive system, and Latvia, Hungary, and Bulgaria, the least progressive. Conclusions Countries relying more on out-of-pocket payments tend to be more regressive overall, suggesting that, from an equity perspective, their role should remain limited. Tax-based systems do not inherently ensure progressivity, especially when relying heavily on regressive consumption taxes. While wealthier countries and those with less income inequality tend to be more progressive, in contrast, Switzerland and Germany both scored among the more regressive countries. Our study shows that policy matters in promoting progressivity in health system revenue collection. Both public and private sources can be regressive if nothing is done. Yet, there are policy instruments that can mitigate regressivity, and even private sources of funds can be made less regressive.

Environnement et santé

Environmental Health

A Flexible Framework for Urgent Public Health Climate Action

JOSEPH, H. A., LEMON, S. C., GOINS, K. V., *et al.*

2025

Am J Public Health 115(7): 1062-1073.

https://doi.org/10.2105/AJPH.2025.308061

Climate change poses profound threats to human safety, health, and well-being. Public health agencies, especially state, territorial, local, and Tribal health departments, can play an essential role in climate change adaptation and mitigation. Public health climate action can protect health, promote health equity, and increase climate change resilience. The Centers for Disease Control and Prevention has updated its original climate and health framework for practitioners and expanded its utility by developing practical guidance. The revised framework, Building Resilience Against Climate Effects, supports health departments and their partners by providing an accessible approach that can be tailored to different contexts. The framework has been updated to center justice, equity, and belonging; integrate climate change mitigation or reduction of greenhouse gas emissions that cause climate change; and address agency capacity. The Building Resilience Against Climate Effects framework also emphasizes collaboration, especially cross-sectoral and community partnerships, communication, and evaluation. Framework elements, key tactics, and guiding principles are presented in a pragmatic, step-by-step implementation guide. The implementation guide can be used by state, territorial, local, and Tribal health departments to galvanize or expand their engagement with public health climate action, which grows more urgent each year. (Am J Public Health. 2025;115(7):1062-1073. https://doi.org/10.2105/AJPH.2025.308061).

A scoping review of interventions to reduce the environmental footprint of healthcare

SEPPANEN, A. V. ET OR, Z.

2025

Value in health 28(7) : 1110-1125

The healthcare sector contributes significantly to global warming, yet strategies for reducing its impact are not well integrated into health policy. This scoping review aimed to identify the range of effective interventions that can reduce the environmental footprint of healthcare, and to provide an overview of their impact. We searched for peer-reviewed articles published in English, French or Swedish between 2010 and September 2024 in Medline and Web of Science, following the Joanna Briggs Institute guidelines and the PRISMA Extension for Scoping Reviews. Publications were selected by two researchers and a documentalist. Data from included studies were extracted and synthesized in tables and described in a narrative synthesis. We identified seven systematic reviews and 44 original research articles. Most of the effective interventions targeted hospitals and varied from energy saving practices and reducing potent anaesthetic gases to changing care protocols and improving waste management. The measured impact of interventions was context-specific and depended on national energy sources. Only a few studies reported on the impact of structural and strategic changes in healthcare provision, across care settings. There is an urgent need for better understanding the costs and benefits of diffusing effective green interventions across care providers and developing more systemic approaches for optimising care provision and use, to achieve a meaningful impact.

État de santé

Health Status

Operationalizing Meaningful Community Engagement to Reduce the Burden of Multiple Chronic Conditions

AUYOUNG, M., FAGAN, P. ET RHOADS, K. F.

2025

American Journal of Public Health 115(S2): S92-S93.
https://doi.org/10.2105/ajph.2025.308179

Cardiologist follow-up and improved outcomes of heart failure: a French nationwide cohort

BAUDRY, G., PEREIRA, O., ROUBILLE, F., *et al.*

2025

European Heart Journal 46(31): 3050-3065.
https://doi.org/10.1093/eurheartj/ehaf218

Outpatient cardiology follow-up is the cornerstone of heart failure (HF) management, requiring adaptation based on patient severity. However, risk stratification using administrative data is scarce, and the association between follow-up and prognosis according to patient risk has yet to be described at a population level. This study aimed to describe prognosis and management across different strata using simple criteria, including diuretic use and prior HF hospitalization (HFH). This nationwide cohort included all French patients reported as having HF in the previous 5 years and alive on 1 January 2020. Patients were categorized into four groups: (i) HFH within the past year (HFH ≤ 1y), (ii) HFH 1–5 years ago (HFH > 1y), (iii) not hospitalized using loop diuretics (NoHFH/LD+), and (iv) not hospitalized without loop diuretics (NoHFH/LD–). Between-group associations, all-cause mortality (ACM), and cardiology follow-up were analysed using survival models.The study included 655 919 patients [80 years (70–87), 48% female]. One-year ACM risk was 15.9%, ranging from 8.0% (NoHFH/LD–) to 25.0% (HFH ≤ 1y). Mortality risk was 1.61-fold higher for NoHFH/LD+, 1.83-fold for HFH > 1y, and 2.32-fold for HFH ≤ 1y compared to NoHFH/LD– (P < .0001). During the first year of follow-up (2020), cardiology consultation rates were similar across groups, with 40% of patients lacking an annual visit. Compared to no consultation, a single cardiology visit in the previous year (2019) was associated with a 6%–9% absolute reduction in 1-year ACM during the following year (2020) across all groups. The number needed to consult (NNC) to prevent one modelled death was 11–16. Additional visits showed greater benefit with increasing HF severity, with NNC ranging from 55 (NoHFH/LD–) to 20 (HFH ≤ 1y). The optimal follow-up to minimize the number of deaths without increasing the total number of consultations was 1 annual visit for NoHFH/LD–, 2–3 visits for NoHFH/LD+ and HFH ; 1y, and 4 visits for HFH ≤ 1y patients. Despite having a HF diagnosis, 40% of patients do not see a cardiologist annually, regardless of disease severity. Simple stratification based on hospitalization history and diuretic use effectively predicts outcomes. Tailoring the annual number of HF consultations according to this stratification could optimize resource use and reduce avoidable modelled deaths.

Healthcare claims and health interview survey data for chronic disease surveillance: agreement and comparative validity of prevalence indicators for 20 chronic conditions in a general population sample in France

COSTE, J., MANDEREAU-BRUNO, L., CONSTANTINOU, P., *et al.*

2025

European Journal of Public Health 35(4): 624-634.
https://doi.org/10.1093/eurpub/ckaf040

Healthcare claims data are increasingly used to derive chronic condition (CC) surveillance indicators, although comparative evidence with self-reported data remains scarce. We explored the agreement and comparative validity (concurrent and predictive) of 20 CC prevalence indicators independently constructed using the French National Health Data System (SNDS) and Health, Health Care, and Insurance Survey (ESPS 2010–2014). Individual data from 5039 ESPS participants aged ≥25 years, representative of the 2010 French general population, were linked to the SNDS. Follow-up data included a 2014 health self-assessment and 5-year mortality. We considered 20 CCs with corresponding SNDS case-identifying algorithms and self-reported information from ESPS, including most cardiovascular diseases and frequent cancers. Kappa statistics assessed agreement between CC indicators across databases. Polytomous and dichotomous logis-

tic regression assessed determinants of disagreement between sources and associations of indicators with health outcomes (concurrent and predictive validity). Prevalence values were much higher with survey data except for hypertension, diabetes, thyroid disorders, epilepsy, and most cancers for which they were closer (±20%) to claims data. Agreement between CC indicators varied from the strongest (hypertension, diabetes, thyroid disorders, most cancers) to the weakest (cardiac rhythm disorders, peptic ulcer, chronic liver diseases). Sex, age, and multimorbidity strongly influenced agreement. Most claims database indicators were more strongly associated with health outcomes. Health interview surveys and healthcare claims-derived indicators are not interchangeable given their specific determinants. Since no general rule applies to all CCs, the advantages and disadvantages of each data source should be closely considered in case-to-case analysis.

Imprecise health beliefs and health behavior

DELAVANDE, A., DEL BONO, E. ET HOLFORD, A.

2025

Journal of Health Economics 102: 103003.

https://doi.org/10.1016/j.jhealeco.2025.103003

This paper examines belief imprecision in the context of COVID-19, when uncertainty about health outcomes was widespread. We survey a sample of young adults a few months after the onset of the pandemic. We elicit individuals' minimum and maximum subjective probabilities of different health outcomes, and define belief imprecision as the range between these values. We document substantial heterogeneity in the degree of imprecision across respondents, which remains largely unexplained by standard demographic characteristics. To assess the behavioral impact of imprecise beliefs, we ask beliefs about future outcomes under hypothetical scenarios that feature different levels of protective behaviors. We find that individuals who expect protective behaviors to reduce not only the subjective probability of a negative health outcome, but also the degree of imprecision associated with it, behave more protectively.

The Impact of a Medical Residents' Walkout on Mortality Rates in South Korea, 2024

KIM, J. H. ET KIM, S.

2025

Health Policy 159: 105375.

https://doi.org/10.1016/j.healthpol.2025.105375

Background At the end of February 2024, over 11,000 medical residents in South Korea collectively resigned in opposition to the government's policy to increase medical school admissions, raising widespread concerns about potential health consequences amid prolonged workforce shortages in acute hospitals. Objective To assess the impact of the medical residents' walkout on mortality rates in South Korea during 2024. Methods We conducted a retrospective observational study using mortality data from Statistics Korea's Vital Statistics (2019-2023) and the Ministry of Interior and Safety's Registration Expiration Statistics (2024). Analyses included crude mortality rates by sex, age, and region; sex- and age-standardized mortality rates; and excess mortality estimations using three modeling approaches with and without COVID-19 fixed effects. Results We found no evidence of increased mortality in 2024. During the walkout period (March-December 2024), mortality rates (577.4 per 100,000) and age-standardized mortality rates (approximately 650 and 750 per 100,000 for females and males) showed no increase from pre-walkout levels. Excess mortality estimates were consistently negative or negligibly small (-11,989 to -2,831 deaths, 95% CI) after controlling for COVID-19 effects, with more pronounced negative values during the walkout period (-30,779 to -7,767). This pattern persisted across demographic groups and regions. Conclusions Even during an unprecedented year-long walkout, mortality patterns in South Korea remained stable, consistent with findings from shorter healthcare strikes. Policymakers should establish robust and democratic dialogue for healthcare reforms, while researchers should investigate non-mortality impacts, including healthcare quality, access, and patient experiences, to develop comprehensive workforce policies.

The Effects of Earned Income Tax Credits on Intergenerational Health Mobility in the United States

JAJTNER, K. ET WANG, Y.

2025

Journal of Health Economics 103: 103048.
https://doi.org/10.1016/j.jhealeco.2025.103048

Intergenerational health mobility is an important marker of health opportunity and equity, yet empirical research in this field remains sparse, particularly concerning the effects of public policies. We present the first empirical evidence of the effects of the Earned Income Tax Credits (EITC), one of the largest and most effective anti-poverty programs in the US, on intergenerational health mobility. We use self-reported health status from the Panel Study of Income Dynamics and explore temporal, geographic, and family structure variations in childhood exposure to maximum EITC benefits. We find that the EITC generally improved intergenerational health mobility, especially upward health mobility.

▶ The opportunities and challenges of integrating health and social care in post-stroke patient journey: perceptions of Estonian professionals

LUBI, K., PEVKUR, H., GROSS-PAJU, K., *et al.*
2025
Health Policy 159: 105377.
https://doi.org/10.1016/j.healthpol.2025.105377

Although strokes are one of the leading causes of death worldwide, their mortality is declining and the demand for integrated care is increasing. Therefore, changes in current health policy approaches are needed. In 2019, the Estonian Health Insurance Fund initiated a pilot study to examine an integrated health and social care approach in the journey of post-stroke patients. West Tallinn Central Hospital piloted the early involvement of community-based social care professionals of the local government. This research was conducted to examine the perceptions regarding an integrated care approach for post-stroke patients of all eleven participants via semi-structured in-depth interviews. By using a qualitative content analysis, participants' experience with the selected approach were analyzed. The findings highlighted the potential and appropriateness of involving community-based social care professionals in the early phase of post-stroke management as part of a multidisciplinary team to enable a holistic, person-centered integrated case approach. The main challenges are the lack of different resources (e.g., specific knowledge, human resource, time), interoperability between health and social care electronic systems, and perceived inappropriateness in addressing a potential change in processes and with involved stakeholders. Thus, a comprehensive health policy and social care policy should be used to tackle these challenges to successfully implement an integrated care model with a multidisciplinary approach.

Géographie de la santé
Geography of Health

▶ Santé publique et Territoires

Santé Publique
2025
Santé Publique vol. 37(HS1): 202p.

Loin de proposer une hiérarchisation des territoires, où certains seraient plus légitimes que d'autres, il s'agit de comprendre que la définition même du territoire dépend des rationalités dont elle procède. À chaque vision du monde, son territoire. Pour certains, au-delà des outils de zonage de l'action publique en santé, le territoire doit nécessairement conserver sa dimension sensible et humaine. Sans cela, la parole des acteurs locaux et de la population du territoire ne peut être entendue. Co-construire la santé publique c'est donc, d'abord, co-construire le territoire en renforçant le lien social, en favorisant la mobilisation des différentes personnes concernées et en développant des interventions adaptées aux spécificités territoriales et aux problématiques rencontrées. C'est dans cet esprit également qu'ont été réunies et présentées les contributions de ce hors-série de Santé Publique (tiré de l'éditorial).

Neighborhood context: Understanding the relationship between national indices of neighborhood risk, individual perception, and posttraumatic stress

BAIER, A. L., NILLNI, Y. I., MANDAVIA, A., *et al.*

2025

Social Science & Medicine 380: 118163.
https://doi.org/10.1016/j.socscimed.2025.118163

Although understudied, emerging research suggests an important link between neighborhood environments and posttraumatic stress disorder (PTSD). National indices of neighborhood disadvantage offer a unique way to objectively assess neighborhoods by linking indices of risk to geocoded residential addresses and research suggests living in a more disadvantaged neighborhood is associated with poorer mental health. Self-report measures offer a subjective appraisal of the circumstances in one's neighborhood yet it is unclear how well perception maps onto objective indices of risk. This study examined the association between three national indices of neighborhood disadvantage and neighborhood perceptions of cohesion, disorder, and danger and whether these relationships were impacted by prior trauma history or PTSD in a sample of 3378 U.S. veterans enrolled in the Longitudinal Investigation of Gender Health, and Trauma (LIGHT) study. Veterans with PTSD resided in more disadvantaged neighborhoods and reported poorer neighborhood cohesion, greater neighborhood disorder, and greater neighborhood danger compared to trauma exposed veterans without PTSD and non-trauma exposed veterans. Findings additionally highlight the ways in which trauma exposure and PTSD symptomology impact the relationship between objective neighborhood indices and perceptions of contextual neighborhood factors and point to important future directions investigating the salience of community level conditions on traumatic stress.

Environmental influences on mental health: eight-year longitudinal data show a bi-directional association between residential mobility and mental health outcomes

HOBBS, M., MOLTCHANOVA, E., MAREK, L., *et al.*

2025

Health & Place 94: 103487.
https://doi.org/10.1016/j.healthplace.2025.103487

Evidence on the environmental determinants of mental health is often cross-sectional. This pre-registered longitudinal study examines the environmental determinants of mental health using eight years of data from the New Zealand Attitudes and Values Study. Among 44,051 adults, findings reveal age, body mass index, and exercise as key individual-level factors impacting mental health, while residential mobility and area-level deprivation emerged as key environmental-level determinants. Increased probability of moving correlates with higher prevalence of depression and anxiety, with subsequent moves worsening area-level deprivation for those with persistent mental health issues. Our findings underscore the significance of environmental factors for mental health, offering insights for population-level interventions.

Obstetric Care Access Declined In Rural And Urban Hospitals Across US States, 2010–22

KOZHIMANNIL, K. B., INTERRANTE, J. D., CARROLL, C., *et al.*

2025

Health Affairs 44(7): 806-811.
https://doi.org/10.1377/hlthaff.2024.01552

We identified obstetric service status for every rural and urban short-term acute care hospital in every US state. During 2010–22, seven states had at least 25 percent of hospitals close their obstetric service lines. By 2022, more than two-thirds of rural hospitals in eight states were without obstetric services.

Rural-Urban Living with Spinal Cord Injury, impact Health, Quality of Life and Integration - Experiences from Denmark

NOE, B. B., HOEJGAARD, A., SKOVBJERG, F., *et al.*

2025

Social Science & Medicine 384: 118300.
https://doi.org/10.1016/j.socscimed.2025.118300

Denmark has a welfare system and relatively small geographical distances. However, the systems are strained, especially in rural areas, which can impact the lives of persons with Spinal Cord Injury (SCI) and increase inequality. This study explores the lived experiences of individuals with SCI living in rural and urban areas regarding their perceived health, quality of life, and integration by applying a phenomenological-hermeneutic approach using reflexive thematic analysis

of sixteen semi-structured interviews with persons previously admitted to the SCI Center of Western Denmark. Three themes were developed: Place of Dwelling Matters, Fight for Rights, and Relations Count. Individuals with SCI in Denmark view their place of dwelling as vital. While they report good health and access to hospital care, they face significant challenges in navigating the municipal health and social systems, with wide variations in support. Those in poorer rural areas, often with limited personal and economic resources, experience the greatest unmet needs. Trusting relationships with municipal assessors are essential to ensure health, quality of life, and integration. The strained municipal economy shifts responsibilities to civil society. However, individuals with limited personal skills in rural areas benefit less from these initiatives. Despite equal rights under the welfare state, rural residents face inequalities due to financial constraints and demographic trends. These disparities exacerbate a growing rural-urban divide in personal resources and access to services, highlighting the need for improved organization of the Danish welfare system as the system's limitations disproportionately affect the most vulnerable individuals in rural areas.

▶ Géographie de la pénurie de médecins spécialistes en France

VIGNERON, E.

2025

Bulletin de l'Académie Nationale de Médecine 209(7).

https://doi.org/10.1016/j.banm.2025.05.011

Résumé Cet article est un travail original reposant sur l'analyse de données publiques disponibles. En lien avec les travaux en cours du groupe de travail sur la « Pénurie de médecins spécialistes » de l'Académie nationale de médecine, un tableau préalable de la situation contemporaine est ici présenté, envisagé sous un angle particulier, celui de la géographie médicale et mobilisant des statistiques descriptives univariées et multivariées. Sur cette base, sont décrites les principales caractéristiques géographiques de la médecine spécialisée : évolution dans le temps très liée à l'histoire de la médecine, inégalités qui se renforcent dans l'espace géographique, évolution vers de nouvelles formes d'exercice mixte au détriment du secteur libéral exclusif, spécialités différemment atteintes par la pénurie, rôle du service public hospitalier dans l'équilibrage de l'offre, boucle de rétroaction avec l'aménagement du territoire. Pour finir sont évoqués quelques principes d'aménagement du territoire, de financement, et d'estimation des besoins. Summary This paper sets out an original study based on available public data. As part of the work of the 'Shortage of specialist doctors' Working Group of the French Academy of Medicine, a preliminary overview of the current situation is presented here, viewed from a particular angle, that of medical geography, based on univariate and multivariate descriptive statistics. The main geographical characteristics of specialized medicine are described: evolution over time closely linked to the history of medicine, increasing inequalities in relation to geographical location, evolution towards new forms of mixed practice to the detriment of the exclusive liberal sector, specialties affected in different ways by shortages, the role of the public hospital service in balancing supply, feedback loop with regional planning. Finally, some principles of regional planning, financing and assessment needs are discussed.

Handicap
Disability

▶ The Effect of anti-discrimination Legislation on Individuals with Disabilities in Nordic Countries

GUGUSHVILI, A., GRUE, J. ET FINNVOLD, J. E.

2025

Social Science & Medicine 383: 118469.

https://doi.org/10.1016/j.socscimed.2025.118469

Nordic countries are renowned for progressive welfare systems and a high quality of life, yet disparities persist between individuals with and without disabilities. This study investigates whether anti-discrimination legislation in these nations enhances socioeconomic outcomes for individuals with disabilities, focusing on

subjective well-being, self-rated health, institutional trust, political engagement, labour market participation, and material conditions. The study uses a quasi-experimental design with a difference-in-differences approach, analysing data from the European Social Survey across Denmark, Finland, Norway, and Sweden. The sample includes 10,974 individuals aged 25-64 reporting significant daily activity limitations due to illness, disability, infirmity, or mental health issues. Outcomes were assessed before and after legislation adoption (2008–2018) using an extended two-way fixed effects model to estimate treatment effects across time and cohorts, with robustness checks via placebo tests and gender stratification. Findings show no significant improvement in subjective well-being, self-rated health, institutional trust, employment, or material conditions following anti-discrimination legislation. A slight increase in voting was observed five waves post-treatment, but placebo tests suggest this may reflect broader trends, not legislation effects. Disability-specific laws in Norway and Denmark showed minor increases in trust and life satisfaction, although parallel trends assumptions held weakly, and placebo results raise questions about causality. We conclude that anti-discrimination laws alone do not substantially enhance socioeconomic outcomes for individuals with disabilities in Nordic countries.

La loi du 11 février 2005, 20 ans après

LEGAY, D., BONNET, C. ET ARVAILLER, J. P.
2025
Pratiques en santé mentale 71(2): 128.

Un idéal de société plus inclusive. 20 ans, ça se fête. La loi « pour l'égalité des droits et des chances, la participation et la citoyenneté des personnes handicapées » a donc 20 ans. Deux décennies après sa publication il nous a semblé intéressant de dresser un premier bilan comme nous l'avions fait dans ces mêmes colonnes pour les 20 ans des lois de 1975, combattues souvent à leur sortie avant que tout leur intérêt n'émerge progressivement. La loi de 2005 est fille de celle de 75 sur le handicap. Elle s'inscrit dans sa continuité car elle ne renonce pas totalement au modèle médical de la déficience, mais s'ouvre à une définition sociale du handicap en référence à la CIF. Si elle lui est fidèle, elle propose aussi un changement de regard et de cap sur le handicap. On se posait en 75 la question « que peut faire la personne handicapée pour s'insérer mieux » à une autre question qui serait : « que peut faire la société pour que personne ne se retrouve en situation de handicap ». D'une loi de protection on est ainsi passé à la promotion de la participation sociale et pour se faire, de la discrimination positive à la non discrimination, de l'accompagnement vers l'insertion à un modèle de société inclusive. Un pas de plus. Dans une première partie de ce numéro, nous tendrons la plume à plusieurs grands témoins des évolutions de notre art à travers ses pratiques et ses lois. Ils sont sociologue, responsable de mouvement, militant ou chercheur. Et puis, dans une seconde notre ambition sera de reprendre largement les évolutions législatives en les articulant aux pratiques cliniques Pour ce faire nous irons rechercher ce qui a pu être écrit sur le sujet au cours de ces 20 dernières années dans notre revue Pratiques en santé mentale. Les préconisations et la philosophie de la loi ont-elles été mises en pratique et comment. Le résultat devrait faire apparaître l'idée que notre revue poursuit toujours le même but militant : accompagner les pratiques des professionnels de terrain dans leur cheminement et leurs interrogations, contribuer à l'humanisation permanente des pratiques et continuer à tenter de promouvoir un idéal de société plus inclusive.

Disabled Patients' Experiences of Healthcare Services in a Nationally Representative Sample of U.S. Adults

STONE, E. M., BONSIGNORE, S., CRYSTAL, S., *et al.*
2025
Health Services Research 60(4): e14598.
https://doi.org/10.1111/1475-6773.14598

ABSTRACT Objective To examine patient-reported experiences of healthcare services by disability status. Study Setting and Design We conducted a cross-sectional analysis of Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures of overall healthcare satisfaction, timeliness of care, and patient-provider interactions to assess differences by disability status and, among those with a disability, between those with sensory, physical, cognitive, or multiple disabilities. Data Sources and Analytic Sample CAHPS measures included in the 2021 Medical Expenditure Panel Survey for U.S. adults. Principal Findings People with disabilities reported significantly lower ratings of healthcare services compared to the general population (7.98, 95% CI: 7.89–8.08 vs. 8.38, 95% CI: 8.34–8.43 on a scale of 0 [worst] to 10 [best]), with the lowest satisfaction among people with multiple disabilities (7.87, 95% CI: 7.72–8.02). Disabled people reported worse experiences on all measures

compared to people without disabilities. People with physical, cognitive, and multiple disabilities reported significantly worse experiences of healthcare services than those with sensory disabilities. Conclusions In a nationally representative sample of U.S. adults, disabled people reported lower satisfaction with healthcare services, less timely care, and worse provider interactions than people without disabilities. Changes to policy and practice are needed to improve healthcare experiences for disabled people.

Hôpital

Hospital

▶ Hospital Entry Improves Quality: Evidence From Common Medical Conditions

BAKER, M. C. ET STRATMANN, T.

2025
Med Care Res Rev 82(4): 319-335.
https://doi.org/10.1177/10775587251321208

To analyze the determinants and effects of hospital entry, we compare entrants' quality of care to incumbent hospitals. Using national hospital-level patient mortality measures from July 2005 to June 2019 for Medicare patients with common medical conditions (heart attack, heart failure, and pneumonia), we establish that entrant hospitals experience 0.27 to 0.76 fewer deaths per 100 patients than incumbent hospitals in the same markets. We further show that new hospitals enter markets where they can provide higher quality care than incumbent hospitals.

▶ Hospital and Skilled Nursing Facility Networks: Informal Relationships and Their Role in the Placement of Traditional Medicare Beneficiaries With Serious Mental Illness

BUCY, T. I., MAUST, D. T. ET CROSS, D. A.

2025
Health Services Research 60(4): e14465.
https://doi.org/10.1111/1475-6773.14465

ABSTRACT Objective To examine the role of hospitals' high-volume preferred provider networks in skilled nursing facility (SNF) placement for traditional Medicare beneficiaries with serious mental illnesses (SMI). Study Setting and Design We describe the differential effect of preferred provider networks on the location of observed SNF admission (i.e., placement) for patients with and without SMI using ordinary least squares (OLS) regression and conditional logistic regression. We also consider the moderating effect of having a co-occurring condition targeted by value-based payment programs. Data Sources and Analytic Sample A 100% sample of Medicare Provider Analysis and Review (MedPAR) files used to identify acute care hospital-to-SNF transitions between 2017 and 2019. Principal Findings Overall, patients with SMI have a lower probability of being admitted to a referring hospital's preferred SNF partner (48.0% vs. 52.4%; $p < 0.001$). We find evidence that incentives introduced through the hospital readmission reduction program (HRRP) moderate this observed relationship, where, relative to their SMI counterparts, individuals with SMI and an HRRP condition have a greater probability of being admitted to a preferred SNF (47.6% vs. 51.1%; $p < 0.001$). We find similar effects using conditional logistic regression, where preferredness is significantly more predictive of admission to the most proximate SNF for patients without SMI versus those with SMI. This effect is again moderated by the presence of a co-occurring HRRP condition. Conclusions Volume-driven preferred partner relationships differentially impact referral patterns for traditional Medicare patients with SMI. Our findings suggest that patients with complex mental and behavioral health conditions may not benefit equally from more targeted investments in transitional care practices that are made in response to these partnerships. Yet our findings are also suggestive of opportunities to leverage existing hospital-SNF relational dynamics to improve the quality of care for a broader group of medically and socially complex patients.

Do faster-trained physicians fill the gaps? Geographic concentration of emergency medicine physicians with different postgraduate training in Ontario Canada

KANTER-EIVIN, D., ARMSTRONG, C., ESLEBEN, A., *et al.*

2025

Health Policy 159: 105360.
https://doi.org/10.1016/j.healthpol.2025.105360

Background Emergency departments in underserved areas face chronic staffing challenges. One possible solution is to use physicians who are quicker to train and more pervasive in lieu of more extensively trained physicians. Canada allows for emergency medicine specialization via a 3-year pathway (CCFP(EM)) and a 5-year pathway (FRCPC) which means different geographic areas are exposed to EM physicians with different training lengths. Methods We examine Ontario, Canada which has both widespread geographic diversity and emergency providers with these two lengths of postgraduate training. We scrape the College of Physicians and Surgeons of Ontario public registry in 2015 and 2024. We map the geographic distribution of physician types and estimate spatial autocorrelation measures using global and local Morans I to determine whether these physicians became more geographically concentrated. Results Between 2015 and 2024, the number of CCFP(EM) and FRCPC physicians increased in overall numbers but their unique locations remained stable. Mapping of these locations suggests clustering into urban or suburban areas in the province. CCFP(EM) physicians have become more concentrated over time (Morans I of 0.234 and 0.308 in 2015 and 2024) relative to FRCPC physicians (Morans I of 0.096 and 0.103). Conclusion We find that, from 2015 to 2024, emergency physicians have become more concentrated in the province of Ontario due to CCFP(EM) physicians concentrating around urban areas with academic medical centres. Policies relying on less extensively trained providers to plug staffing gaps may not necessarily be effective in improving equitable access to physicians.

Introducing rational agent access model to enhance scene-to-hospital accessibility of emergency medical services

KIM, K., KWON, K. ET HORNER, M. W.

2025

Applied Geography 182: 103721.
https://doi.org/10.1016/j.apgeog.2025.103721

Emergency medical services (EMS) are crucial for patient survival, and spatial access to EMS is among the most important factors from a spatial perspective. While existing spatial accessibility models applied to EMS were mostly the nearest facility model and two-step floating catchment area (2SFCA) methods, we considered the rational agent access model (RAAM) as an approach that incorporates EMS personnel's hospital-seeking behavior regarding available emergency rooms and the golden time to increase a patient's survival. We compared the generalized 2SFCA (G2SFCA) method and RAAM, validating both using actual patient transport data in Seoul, South Korea. Results show that the RAAM has small locational accessibility gaps within the study area compared with the G2SFCA method, and it identifies islands that have low accessibility areas in central Seoul, which the G2SFCA method cannot. Furthermore, RAAM correlates better with actual patient transport times, hospital waiting times, and patient allocation patterns than the G2SFCA method does, indicating that it reflects EMS personnel's behavior more accurately. Based on these results, we suggest that while 2SFCA-based methods are useful for general healthcare access measurement, RAAM provides a better measurement for EMS, where resource constraints and golden time are critical.

Interdisciplinary Team-Based Intervention to Reduce Acute Care Utilization Among Emergency Department Multi-Visit Patients

KIM, Y. K., PARK, N., EVERETT, J. H., *et al.*

2025

Health Services Research 60(4): e14458.
https://doi.org/10.1111/1475-6773.14458

ABSTRACT Objective To evaluate the impact of the emergency department (ED) Multi-Visit Patient (MVP) Program, a novel team-based approach to supporting patients with frequent ED utilization. Study Setting and Design The ED MVP Program identified patients with frequent ED visits, conducted comprehensive chart reviews, and implemented tailored care plans to address healthcare barriers and social determinants of health. A comparison group included eligible patients who did not receive the intervention as well as those not yet treated at a given month. We conducted a quasi-experimental study using difference-in-differences analysis with dynamic effects. Data Sources and Analytic Sample Acute care utilization (ED visits, observation stays, inpatient admissions) and 30-day

readmission data were extracted from the electronic health record system across a multi-hospital not-for-profit healthcare system in the Baltimore–Washington metropolitan area. Principal Findings Compared with controls, patients receiving ED MVP intervention had 1.94 fewer acute care hospital visits (95% confidence interval [CI]: –2.54, –1.34) and 2.42 fewer days of acute care utilization (95% CI: –3.19, –1.64) in the following 12 months. There was also a small reduction in 30-day inpatient readmissions, averaging 0.08 fewer readmissions (95% CI: –0.16, –0.01). Conclusions This study provides strong evidence for the effectiveness of a tailored care intervention to reduce acute care utilization among patients with frequent ED utilization.

Do For-Profit Hospitals Cream-Skim Patients? Evidence from Inpatient Psychiatric Care in California

LEE, D., BASU, A., DUGAN, J. A., *et al.*
2025
Journal of Health Economics 102: 103027.
https://doi.org/10.1016/j.jhealeco.2025.103027

ABSTRACT The paper examines whether, among inpatient psychiatric admissions in California, for-profit (FP) hospitals engage in cream skimming, i.e., choosing patients for some characteristic(s) other than their need for care, which enhances the profitability of the provider. We propose a novel approach to identify cream skimming using cost outcomes. Naïve treatment effect estimates of hospital ownership type consist of the impact of differential patient case mix (selection) and hospital cost containment strategies (execution). In contrast, an instrumental variable (IV) approach can control for case mix and establish the causal effects of ownership type due to its execution. We interpret the difference in naïve and IV treatment effects to be driven by FP hospitals' selection (cream skimming) based on unobserved patient case mix. We find that FP specialty hospitals are more likely to treat high-cost patients than their not-for-profit (NFP) counterparts, providing no evidence of cream skimming by FP hospitals. Our findings may alleviate concerns about the recent proliferation of FP psychiatric hospitals, particularly regarding cream skimming.

Site-Neutral Payment Reform: Little Impact On Outpatient Medicare Spending Or Hospital-Physician Integration

POST, B., THAI, N., NOOR, E. A. M., *et al.*
2025
Health Affairs 44(6): 659-667.
https://doi.org/10.1377/hlthaff.2024.00972

Medicare pays hospital outpatient departments higher rates than physician-owned practices, leading to higher spending and incentivizing hospitals to acquire physician practices. The Bipartisan Budget Act of 2015 introduced site-neutral payments for new outpatient departments but excepted existing ones. To evaluate the impact of this law, we analyzed 2013–20 Medicare claims data, comparing spending under site-neutral rates with spending under site-based rates and using difference-in-differences analysis to assess the effect on hospital-physician integration. During the period 2017–20, most Medicare payments were unaffected by the Bipartisan Budget Act: Only 1.5 percent of outpatient department spending occurred at site-neutral facilities. Counties subject to the Bipartisan Budget Act did not show a statistically significant difference in the percentage of hospital-integrated physicians (2020 estimate: –0.2 percentage points). The act did little to reduce Medicare spending or hospital-physician integration, suggesting that site-neutral legislation could be strengthened by reducing exceptions.

Factors Influencing Rural Hospitals' Decisions To Join An Alternative Payment Model: A Mixed-Methods Study

RAK, K. J., BOURNE, D. S., BARNES, J., *et al.*
2025
Health Affairs 44(7): 796-805.
https://doi.org/10.1377/hlthaff.2024.01609

Hospitals' participation in voluntary Alternative Payment Models has implications for model evaluation and performance. This mixed-methods study examined factors underlying hospitals' decision to participate in the Pennsylvania Rural Health Model (PARHM), a voluntary model under the Center for Medicare and Medicaid Innovation that combined hospital global budgets and care transformation plans. Quantitative analyses tested for pre-PARHM differences in characteristics, and qualitative analyses examined contextual factors identified in interviews with hospital administrators across participating and eligible nonparticipating hospitals. At baseline, hospitals that joined PARHM

had smaller total margins, fewer inpatient discharges, and greater likelihood of being independent compared with nonparticipating hospitals. Qualitative findings suggested that the desire to improve financial stability and maintain independence influenced decisions to participate, whereas the desire to preserve operational autonomy and flexibility for future growth influenced the choice not to participate. These findings can inform the development and targeting of future Alternative Payment Models, with specific considerations for rural hospitals.

Living alone and provider behaviour in public and private hospitals

SICILIANI, L., WEN, J. ET GAUGHAN, J.

2025

Journal of Health Economics 102: 103016.

https://doi.org/10.1016/j.jhealeco.2025.103016

Following COVID-19, hospitals in many OECD countries are under pressure to absorb backlogs accumulated due to the suspension of health services. Reductions in length of stay can generate capacity to treat patients and increase efficiency. Personal circumstances, such as living alone, can affect how long patients stay in hospital. We test whether such non-clinical factors affect care received by patients. Several countries are experiencing an increase in the number of elderly people who live alone. Patients who live alone may lack support at home leading to delayed discharges despite being clinically fit. We test whether living alone affects length of stay of publicly-funded patients treated by public and private hospitals requiring hip replacement, a common planned surgery, in England. Private providers have stronger incentives to contain costs, which could reduce the extent to which non-clinical factors such as living alone are taken into account when providers discharge patients. Using administrative data and controlling for a rich set of patient characteristics, and hospital and local supply factors, we provide evidence that living alone increases length of stay. The effect is substantive and larger for public hospitals and older patients. It is similar for patients living in urban and rural areas, and across socioeconomic status. More broadly, the study shows that non-clinical factors can affect the care received by patients.

Financial penalty associated with a decline in hospital-acquired complications in Australia

SLAWOMIRSKI, L., OTAHAL, P., HENSHER, M., *et al.*

2025

Health Policy 161: 105416.

https://doi.org/10.1016/j.healthpol.2025.105416

Background Adverse events during hospital care are a global concern. The evidence for addressing unsafe acute care using pay-for-performance (p4p) is inconclusive. Objective To examine association between the introduction of a financial penalty on 1 July 2018 and the prevalence of 13 high-priority hospital-acquired complications (HACs) in Australian public hospitals. Methods Administrative data on every Australian public hospital separation (age >17 years) between 1 January 2014 and 30 June 2021 was used to analyse changes in quarterly HAC prevalence (per 1,000 multi-day separations), standardized to the study population, using two interrupted time series methods: generalized least squares (GLS) with autoregressive moving average (ARMA) errors, and a Bayesian structured time series. Results Just under 20 million separations took place over the study period with 947,057 (4.7%) (mean age 69 (SD: 18), 48% female) recording at least one HAC and 1,263,646 HACs overall. Our GLS model estimated a decline of 17% (95% CI 12 – 22%) in HAC prevalence associated with the introduction of the penalty. The Bayesian model estimated a 26% (23 – 29%) decline. Most of the decline occurred during a 12-month roll-in period. Results suggest that 98,970 fewer inpatients experienced a HAC from 1 July 2018 to 30 June 2021 compared to the modelled counterfactual. Conclusions Implementation of a financial penalty was associated with a substantial decline in HACs. Few other p4p policies have been associated with reductions in inpatient harm. Future research should examine local HAC trends and investigate what other factors may have contributed to the change.

Inégalités de santé

Health inequalities

Reassessing human capital and health capital over the life course: Causal mediation analysis of higher education, health, and wages.

ARAKI, S.

2025

Social Science & Medicine 381: 118299.

https://doi.org/10.1016/j.socscimed.2025.118299

The wage return to education has long been explained by human capital theory. However, little is known about the mediating role of improved health, another key component of human capital, in connecting educational attainment and economic gains over the life course. This paper uses data from the National Longitudinal Survey of Youth 1979 in the United States to reassess the economic value of education from a life course perspective, focusing on the interplay of college completion, health, and wages. Causal mediation analysis coupled with the recentered influence function first illuminates substantial returns to education, net of health mediation, particularly for upper quantiles of the wage distribution. College completion is linked to approximately a 0.3 increase in log hourly wages on average, and the effect estimates rise to over 0.5 at the 90th quantile. Nevertheless, as individuals age over 20 years from their mid-thirties, the mediating role of health increases, albeit with a relatively small magnitude, accounting for over 9 % of the total effect estimates in their mid-fifties. This indirect contribution of education through health capital is especially evident within the lower to middle wage quantiles. The observed structure is consistent across genders. These results suggest that college completion as such demonstrates a boosting effect on higher wages throughout one's career, whereas the pathway along enhanced health serves as a protective factor against falling into lower wage strata later in life.

Longevity, Education, and Income: How large is the triangle?

BLEAKLEY, H.

2025

Journal of Health Economics 103: 103052.

https://doi.org/10.1016/j.jhealeco.2025.103052

While health affects economic development and well-being through a variety of pathways, one commonly suggested channel is a "horizon" mechanism in which increased longevity induces additional education. A recent literature devotes much attention to how much education responds to increasing longevity, while this study asks instead what impact this specific channel has on wellbeing (welfare). I note that death is like a tax on human-capital investments, which suggests using a standard tool of introductory economics: triangles. I estimate the (triangular) gain from reoptimization when education adjusts to lower adult mortality. Even for implausibly large responses of education to survival differences, almost all of today's low-human-development countries, if switched instantaneously to Japan's survival curve, would place a value on this channel of less than 3% of income. (This contrasts with a 40% 'rectangle' that they would gain even if education were held fixed.) Calibrating the model instead with well identified studies, I find that the horizon triangle for the typical low-income country is less than a percent of lifetime income.

The challenge of the first 1,000 days. The dynamics of early-life health inequalities in a universal healthcare system: Evidence from Italy

BERTA, P. ET TURATI, G.

2025

Health Policy 161: 105390.

https://doi.org/10.1016/j.healthpol.2025.105390

Research in Context: (1) What is already known about the topic? Low birth weight (LBW) is a key marker of early-life health disadvantage, associated with increased mortality, delayed development, and long-term socioeconomic challenges. Health disparities related to LBW are predictive of future health outcomes and life trajectories. Although universal healthcare systems can mitigate such inequalities, their effectiveness varies across health domains and population subgroups. (2) What does this study add to the literature? This study examines how LBW-related health disparities evolve during early childhood within the universal healthcare system of Lombardy, Italy. Using robust statistical approaches, including twin fixed-effect models, the study shows

that initial disadvantages in hospitalization rates and severity substantially decrease within the first 1,000 days of life, particularly for nervous and digestive system conditions. However, disparities persist in respiratory diseases, indicating uneven mitigation across health domains. The study contributes new evidence on how universal healthcare can promote health equity in early life, while highlighting residual areas of concern. (3) What are the policy implications? The findings suggest that universal healthcare systems can significantly reduce health inequalities linked to LBW, but targeted interventions are necessary to address persistent disparities—especially in respiratory health. Policymakers should consider strengthening prenatal and neonatal care and designing condition-specific strategies that extend beyond infancy. Tailored support for LBW infants can further improve long-term outcomes and enhance the overall effectiveness of universal healthcare in promoting equitable health. Background: Early-life health inequalities can shape long-term health outcomes. This study examines disparities in hospitalization rates and severity between low- and normal-birth-weight children aged 0–3 years in Lombardy, Italy, under a universal public healthcare system. Objective: To analyze the evolution of early-life health inequalities in hospitalization rates and severity between low- and normal-birth-weight children. Methods: A retrospective longitudinal study leveraging a unique administrative dataset that integrates birth records and hospital discharge data for a large cohort of children in Lombardy. This approach allows for a robust analysis of hospitalization probabilities, total reimbursement costs, and hospital length of stay over the critical first 1,000 days of life. Subgroup analyses focus on nervous, digestive, and respiratory diseases. Twin birth data are used to strengthen causal inference. Results: Low-birth-weight children experience higher hospitalization rates and greater severity in the first year of life, but disparities substantially decline over time, with no significant differences in costs or hospital stays after 1,000 days. While inequalities decrease most for nervous and digestive system diseases, they persist for respiratory conditions. Findings are consistent in twin analyses, reinforcing the study's robustness. Conclusion: By leveraging rich administrative data and a longitudinal framework, this study highlights the capacity of a universal healthcare system to mitigate early-life health disparities, particularly for nervous and digestive conditions. However, persistent respiratory disparities call for targeted interventions. These insights can inform future policies aimed at enhancing health equity from birth.

Is the quest for efficiency harmful to health equity? An examination of the health efficiency-equity nexus in OECD countries over the past two decades

BOUSMAH, M. A., ABU-ZAINEH, M., COMBES, S., *et al.*
2025

Social Science & Medicine 383: 118379.
https://doi.org/10.1016/j.socscimed.2025.118379

Background Has the quest for efficiency in OECD health systems impacted the social gradient of health? We examined the cross-dynamics of the health system equity-efficiency nexus among OECD countries in the past two decades. Methods We used a three-step methodology based on annual macro-level data from 36 OECD countries for the period 2004-2021. First, we estimated the efficiency of health systems using a stochastic frontier analysis. We then assessed the equity of health systems using simple measures of income-related inequality in self-assessed health. Lastly, we estimated the dynamic relationship between health system efficiency and equity using a panel Granger causality analysis. We also stratified the analysis by type of health system: viz. publicly- vs. privately-dominated health service provision. Findings We find evidence for a bidirectional causality between health system efficiency and equity. An increase in health system efficiency leads to an increase in socioeconomic inequalities in health; a result particularly salient in countries with predominantly private health service provision. Interestingly, decreases in socio-economic inequalities in health are likely to lead to higher health system efficiency, especially in countries where the health system relies predominantly on private provision. Interpretation The pursuit of efficiency gains in OECD health systems has not been a precondition for socioeconomic equity in health. Adverse effects of efficiency-seeking interventions on health equity are particularly apparent in the private provision of healthcare. However, addressing health inequalities provides a plausible route to enhance efficiency.

Neighborhood socioeconomic disadvantage and travel time to diabetes prevention programs in Maryland

BUCHONGO, P., CHEN, J., NGUYEN, Q., *et al.*
2025

Health & Place 94: 103470.
https://doi.org/10.1016/j.healthplace.2025.103470

Background Transportation issues are a significant barrier for accessing the National Diabetes Prevention Program (NDPP), which remains an effective intervention to prevent type 2 diabetes. Although the link between neighborhood socioeconomic disadvantage and access to health care resources has been widely studied, its impact on travel time and access to NDPP has been underexplored. Methods Medicaid and private claims data for 2019 from the Maryland Medical Care Data Base were linked to 2019 Social Deprivation Index (SDI) data to measure neighborhood socioeconomic disadvantage. Google Distance Matrix Application Programming Interface key for Google Maps Platform was used to generate travel time estimates for enrollees diagnosed with prediabetes. Then adjusted generalized linear regression models using SDI quintiles and the interaction of SDI quintile and race and ethnicity were fitted to predict driving and public transit travel time to the nearest NDPP. Findings Enrollees living in neighborhoods with the highest SDI scores (most disadvantaged) had significantly shorter driving and public transit travel time to the nearest NDPP compared to enrollees living in neighborhoods with the lowest SDI scores (least disadvantaged). We found differences in the magnitude of shorter travel times across racial and ethnic groups and transportation mode. Conclusion Our findings fill a major gap in the literature on neighborhood socioeconomic disadvantage and travel time to NDPP. Findings highlight the role state policies may have had in expanding access to NDPP. More research is needed to examine strategies to address racial and ethnic disparities, and transportation needs to improve access to in-person NDPP.

Blood Sugar, Social Struggles: Biomarkers of Socioeconomic, Gender, and Ethnic Health Disparities in Type 2 Diabetes Care

CONSOLAZIO, D. ET RUSSO, A. G.

2025

Social Science & Medicine: 118435.
https://doi.org/10.1016/j.socscimed.2025.118435

Socioeconomic, gender, and ethnic disparities significantly affect Type 2 Diabetes Mellitus (T2DM) management, impacting healthcare access, treatment adherence, and outcomes. This study explores inequalities in glycaemic monitoring and testing in Milan (Northern Italy) using glycated haemoglobin data. Analysing administrative data from 56,795 T2DM patients aged 40 to 85, we assess the interplay of education, gender, and ethnicity in diabetes care. Findings show that all three dimensions impact T2DM care. A clear socioeconomic gradient exists among Italians. Males have higher testing rates and lower blood glucose levels than females, but inequalities are similar. Ethnic disparities are pronounced, with foreign-born individuals facing worse outcomes than Italians. Trends vary across groups, highlighting significant gender differences and sometimes reversed social gradients. These results underscore the need for targeted interventions to address structural inequalities in diabetes care and reduce health disparities. Integrating biomarkers into social epidemiology provides a framework for understanding how social determinants translate into biological outcomes, thereby guiding equitable healthcare policies.

Influence of socioeconomic position on the relationship between long COVID and health-related quality of life: A nationwide random sampling survey in France in autumn 2022

DELPIERRE, C., LEMOGNE, C., STEICHEN, O., *et al.*

2025

Social Science & Medicine 382: 118368.
https://doi.org/10.1016/j.socscimed.2025.118368

Socioeconomic position (SEP) is associated with long COVID risk and health-related quality of life (HRQoL). SEP may influence the relationship between long COVID and HRQoL, but evidence is lacking. Our study therefore evaluated the influence of SEP on the relationship between long COVID or post-COVID-19 condition (PCC) and HRQoL in a representative sample of the general French population. After the Omicron waves in autumn 2022, a representative sample of 1,448 adults infected with SARS-CoV-2 was assessed for post-COVID-19 symptoms, demographics, SEP, health factors and HRQoL using the PROMIS-29 questionnaire measuring HRQoL in eight domains (physical function, anxiety, depression, fatigue, sleep disturbance, ability to participate in social roles and activities, pain interference and pain intensity). PCC was defined according to the World Health Organisation. A conceptual model of the relationship between PCC and impaired HRQoL was proposed. Modifying effects of age, sex and SEP variables (geographic origin, education, household size, occupational category, employment status, household income) on the relationship between PCC and HRQoL were tested in the framework of this model. PCC, low education level and household income negatively impacted overall HRQoL and 5/8 PROMIS-29 domains (depression, fatigue, sleep disturbance, social

participation and pain intensity). PCC-induced HRQoL impairment was significantly higher among people without a long tertiary education, unemployed individuals, business owners and entrepreneurs and people from mainland France. Healthcare providers and policymakers should better account for the differential impact of long COVID on HRQoL according to SEP. They should promote strategies to reduce health inequalities and lessen the burden of this condition in the general population.

Socioeconomic inequalities and diabetes complications: an analysis of administrative data from Hungary

ELEK, P., MAYER, B. ET VARGA, O.

2025

European Journal of Public Health 35(4): 598-604.

https://doi.org/10.1093/eurpub/ckaf038

Diabetes complications are associated with increased healthcare costs and worsened patient outcomes. In this paper, we analyse how individual-level demographic and territorial-level socioeconomic and healthcare variables influence the presence and severity of diabetes complications and their relationship with mortality. Our study utilizes anonymized administrative healthcare data on all diabetes patients of Hungary between 2010 and 2017. We construct settlement-year level and individual-year level panel datasets to analyse diabetes prevalence, incidence and complications, employing Poisson and logit models to explore associations between complications and the explanatory variables. The adapted Diabetes Complications Severity Index (aDCSI) is employed to quantitatively evaluate the severity of complications by aggregating individual complication scores from ICD-10 diagnosis codes. We find that diabetes prevalence and incidence are higher in settlements with above-median unemployment rates, where patients exhibit more severe complications, as shown by higher average aDCSI scores. Among socioeconomic factors, unemployment rate is particularly associated with increased aDCSI scores, while better healthcare access is associated with lower aDCSI scores in unadjusted but with higher scores in adjusted models. The presence and severity of complications, especially renal, cardiovascular and peripheral vascular ones, substantially increase 5-year inpatient mortality. Most of the mortality difference by settlement-level unemployment rate disappears when complications are accounted for. We conclude that socioeconomic inequalities, particularly higher unemployment rates, are strongly linked to diabetes complications and associated mortality risk. Addressing these disparities through improved healthcare accessibility and targeted public health strategies could play a crucial role in reducing the burden of diabetes-related complications and improving patient outcomes.

Patient choice and socioeconomic disparities in the quality of healthcare: Evidence from Swedish registry data

ELLEGÅRD, L. M., KJELLSSON, G., KOVACS, R., *et al.*

2025

Social Science & Medicine 383: 118351.

https://doi.org/10.1016/j.socscimed.2025.118351

This study explores socioeconomic disparities in how patients trade off quality against other features when choosing their primary care provider. We use a unique registry dataset linking the choices of individuals who recently moved to a new market, and therefore need to select a new provider, with detailed individual-level measures of socioeconomic status (SES) and provider-level measures of patient satisfaction, clinical quality and travel distance in a large Swedish region. We find significant disparities in patient choice based on SES, as high-SES individuals are consistently more likely to select higher quality providers. However, the results also suggest that most of the SES disparities in observed quality are linked to differences in the availability of high-quality providers within an acceptable travel distance. Our findings suggest that patient choice can widen, rather than reduce, disparities in population health by SES – if spatial inequalities in access to high-quality care are not addressed beforehand.

Barriers to healthcare access for irregular immigrants after their arrival in Spain: a systematic review

FAGUNDO-RIVERA, J., GARCIA-LOZANO, M. S., PORTERO-PRADOS, F. J., *et al.*

2025

European Journal of Public Health 35(3): 407-422.

https://doi.org/10.1093/eurpub/ckaf042

Examining the barriers encountered by irregular immigrants in accessing the public health system is crucial for the continuity of healthcare processes. This approach not only heightens patient-centered care but also fosters long-term public health preparedness and social cohesion. The aim of this review was to exam-

ine the existing barriers to accessing the Spanish healthcare system for the immigrant population. A systematic review of original articles was conducted based on the PRISMA methodology. Studies registered in PubMed, Scopus, CINAHL, LILACS, Web of Science, and Enfispo were analyzed. A total of 4773 articles were identified, of which 15 were selected for review. Among the selected articles, 10 employed qualitative methodologies, 1 utilized a mixed methodology, and 4 used quantitative methodologies. A variety of access barriers related to communication, administrative issues, and misinformation about legal aspects were identified. It was noted that one in five immigrants has experienced at least one barrier to accessing the Spanish healthcare system. Barriers to access to the health system are clearly shared by both immigrants and healthcare professionals. Barriers to access to the health system are a result of the coalition of organizational factors, cultural experiences, and socioeconomic and educational determinants. Access to healthcare for irregular migrants in Spain is hindered by language barriers, misinformation, and administrative obstacles, exacerbated by the COVID-19 pandemic. Policies are needed to ensure equitable care, enhance communication, streamline procedures, and strengthen collaboration with non-governmental organizations and cultural mediators to optimize healthcare responses.

▶ Comparison of Machine Learning Algorithms Identifying Children at Increased Risk of Out-of-Home Placement: Development and Practical Considerations

GORHAM, T. J., HARDY, R. Y., CICCONE, D., *et al.*

2025

Health Services Research 60(4): e14601.

https://doi.org/10.1111/1475-6773.14601

ABSTRACT Objective To develop a machine learning (ML) algorithm capable of identifying children at risk of out-of-home placement among a Medicaid-insured population. Study Setting and Design The study population includes children enrolled in a Medicaid accountable care organization between 2018 and 2022 in two nonurban Ohio counties served by the Centers for Medicare and Medicaid Services-funded Integrated Care for Kids Model. Using a retrospective cohort, we developed and compared a set of ML algorithms to identify children at risk of out-of-home placement within one year. ML algorithms tested include least absolute shrinkage and selection operator (LASSO)-regularized logistic regression and eXtreme gradient-boosted trees (XGBoost). We compared both modeling approaches with and without race as a candidate predictor. Performance metrics included the area under the receiver operating characteristic curve (AUROC) and the corrected partial AUROC at specificities ≥ 90% (pAUROC90). Algorithmic bias was tested by comparing pAUROC90 across each model between Black and White children. Data Sources and Analytic Sample The modeling dataset was comprised of Medicaid claims and patient demographics data from Partners For Kids, a pediatric accountable care organization. Principal Findings Overall, XGBoost models outperformed LASSO models. When race was included in the model, XGBoost had an AUROC of 0.78 (95% confidence interval [CI]: 0.77–0.79) while the LASSO model had an AUROC of 0.75 (95% CI: 0.74–0.77). When race was excluded from the model, XGBoost had an AUROC of 0.76 (95% CI: 0.74–0.77) while LASSO had an AUROC of 0.73 (95% CI: 0.72–0.74). Conclusions The more complex XGBoost outperformed the simpler LASSO in predicting out-of-home placement and had less evidence of racial bias. This study highlights the complexities of developing predictive models in systems with known racial disparities and illustrates what can be accomplished when ML developers and policy leaders collaborate to maximize data to meet the needs of children and families.

▶ A Population-Based Exploration of Immigrants undergoing General Surgery Procedures in British Columbia: Do immigrants present for emergency surgeries more than non-immigrants?

GUO, M., MOURAD, N., KARIMUDDIN, A., *et al.*

2025

Health Policy 161: 105410.

https://doi.org/10.1016/j.healthpol.2025.105410

Background : Canada's growing immigrant population faces language and cultural barriers that hinder timely access to healthcare. The balance between elective and emergency general surgery (EGS) reflects immigrant's access to healthcare since many EGS cases are avoidable through treatment as elective procedures. Objective : This study examines whether immigrants are more likely to undergo EGS than non-immigrants and measures whether language proficiency or access to primary care plays a role in disparity in access to care. Methods : All general surgery procedures performed in British Columbia, Canada between 2013 and 2021 were identified using a population-based longitudinal

administrative data that linked immigration data with physician billing and hospital data. The primary outcome was whether patients' surgery was elective or EGS and the primary exposure was immigrant status. The odds of EGS between immigrants and non-immigrants was estimated adjusting for patient and system-level differences. The analysis compared immigrants with and without English proficiency on arrival to Canada. Results : Of 237,054 general surgery procedures, 30.7% were EGS and 15.2% involved immigrants. Immigrants had slightly higher odds of undergoing emergency general surgery (EGS) than non-immigrants. Immigrants not fluent in English had 16% higher odds of EGS (OR: 1.16, 95%CI 1.03-1.32). Immigrants with fewer GP contacts were more likely to undergo EGS (45.5% versus 42.2%, $p < 0.01$). Conclusions : Immigrants with language barriers and who accessed primary care less often were more likely to require EGS. These findings highlight the need for system-level interventions to reduce immigrants' reliance on emergency surgical care.

Childhood Neighborhoods and Health in Later Life: Hospital Admissions in Sweden 1939–2015

HEDEFALK, F., VAN DIJK, I. K. ET DRIBE, M.

2025

Social Science & Medicine 381: 118301.

https://doi.org/10.1016/j.socscimed.2025.118301

We study the association between childhood neighborhood socioeconomic status (SES) (ages 1-15) and hospitalization with preventable-type disease in adulthood, using geocoded longitudinal microdata for a Swedish city (1939–1967) linked to national registers (1973–2015). Observing the full residential histories at the address level for the entire population, we construct dynamic and cumulative individual neighborhoods and measure SES of parents to similarly-aged neighboring children. In the nationwide follow-up, we measure later-life health (age group 45–54) using information on hospital admissions grouped by disease preventability. Our findings show that growing up in the highest-status neighborhoods lowers the risk of hospital admission in adulthood for men, but not for women. The associations do not differ by preventability and persist after including a range of control variables. The findings demonstrate the importance of childhood neighborhood conditions for health throughout the life course.

Under What Conditions Do People Accept Health Inequality? A Cross-National Regression Analysis of OECD Countries

KIM, M. ET CHOI, Y. J.

2025

Health Policy 161: 105398.

https://doi.org/10.1016/j.healthpol.2025.105398

ABSTRACT Background Health inequality remains a persistent challenge for welfare states. Over the past two decades (1999–2019), neoliberal policies and rising inequality have significantly influenced these attitudes. Objective The study investigates the evolution of public attitudes towards health inequality in OECD countries and evaluates the interaction between institutional structures and societal norms over time. Methods This study employs a longitudinal quantitative design utilizing data from the International Social Survey Programme (ISSP) Social Inequality module (1999, 2009, 2019) across 12 OECD countries. Descriptive analysis and multiple linear regression models were conducted to test grievance and policy feedback theories. Results In 1999, countries with lower public healthcare spending and higher inequality exhibited strong opposition to health inequality. However, by 2019, attitudes shifted, with opposition decreasing in highly unequal societies and increasing in countries with robust public healthcare spending. Regression analyses revealed significant changes over time, suggesting a transition from grievance-based responses to inequality toward acceptance influenced by policy feedback effects. Conclusions The findings underscore the need for policymakers to consider long-term policy impacts on public perceptions. Institutional frameworks fostering equitable healthcare access can counter the normalization of inequality, thereby promoting societal resistance to health disparities.

Income-Related Inequalities in Future Health Prospects

KJELLSSON, G., PETRIE, D. ET VAN OURTI, T.

2025

Health Econ 34(8): 1426-1442.

https://doi.org/10.1002/hec.4965

Measuring health disparities is key to monitoring health systems, but hitherto disparities in the individual risk people face about their future health has been neglected. This paper integrates individual health risk into income-related health inequality measurement. We develop a rank dependent health inequality index

that considers inequalities in each individual's expected future health and the dispersion of their future health prospects. It is useful when a social planner wants to account for risk averse preferences in the assessment of income-related inequalities of future health prospects. The empirical application using Australian longitudinal data highlights that neglecting individual risk underestimates income-related inequalities in future health prospects since the poor not only face worse expected future health, but also faced greater dispersion in their future health prospects compared to the rich.

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

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

2025

Social Science & Medicine 381: 118212.

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

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

Health status of a migrant population: a survey within an Extraordinary Reception Centre in Parma, Northern Italy

MAZZOLI, R., SANTUNIONE, A. L., MAREZZA, F., *et al.*

2025

European Journal of Public Health 35(4): 680-686.

https://doi.org/10.1093/eurpub/ckaf076

The steady flow of migrants is an ongoing challenge that requires health systems to adapt to unique health needs and to address inequalities. For this reason, comprehensive screening, early intervention, and culturally sensitive care are vital to improve migrants' health outcomes. We assessed migration history and health status in 536 migrants housed at "Svoltare ONLUS", an Extraordinary Reception Centre in Parma (Northern Italy), from 2015 to 2018. The focus was on migration journey characteristics and motivations, and testing for infectious diseases such as hepatitis B (HBV) and C (HCV), HIV, tuberculosis (TB), syphilis, and parasitosis. Migrants were overwhelmingly male (95.9%), with a mean (range) age of 26 (18–50) years. The majority originated from Sub-Saharan Africa (83.2%), with Nigeria as the predominant country. Most migrants entered via Libya (87.1%), disembarking primarily in Southern Italy, particularly Sicily (75.4%). High prevalence rates were found for HBV (48.8%), TB (27.8%), and parasitosis (23.1%), particularly among those from Western Africa. In contrast, HCV (2.61%), chronic hepatitis (5.41%), syphilis (2.99%), and HIV (1.31%) were less common. These trends are consistent with disease epidemiology in migrants' countries of origin as well those visited during the journey. Given the higher prevalence of infectious diseases among migrants compared to the general population in Italy, it is essential to enhance public health measures. This includes implementing timely screening services, targeted surveillance, and prompt treatment upon arrival at reception centers to protect both migrant and community health.

The associations between intergenerational mobility of income and cognitive function in midlife – The Young Finns Study

NURMI, A., VEPSALAINEN, T., PAHKALA, K., *et al.*

2025

Social Science & Medicine 382: 118325.
https://doi.org/10.1016/j.socscimed.2025.118325

ABSTRACT Background Systematically high and upward mobile (lower childhood and higher adulthood) socioeconomic status (SES) has been suggested to be associated with better overall cognitive function in adulthood compared to systematically low or downward mobile (high childhood and low adulthood) SES. Methods Participants' SES mobility was assessed using data on childhood family income (N=3596, age 3-18) and own adulthood income (N=1941, age 34-49). Adulthood learning and memory, working memory, information processing, and reaction time were measured using a computerized test. Altogether, 1804 participants had data on life-course income level and cognitive function in adulthood. Results Compared to participants with stable high income, those with stable low, downward, or upward mobile income had worse memory and learning, and information processing. Participants with stable low or downward mobile income had worse working memory and reaction time. The results persisted after adjusting for age, sex, childhood/adulthood lifestyle, cardiovascular risk factors, and polygenic risk score for cognitive function. Conclusions Individuals with stable high income may have better midlife cognitive function. This finding highlights the role of life-course SES for disparities in adulthood cognitive function. Understanding the role of early-life determinants of midlife cognitive function is important, as this knowledge may be applied to the early promotion of adulthood cognitive health.

The food (in)security and mental health nexus in high-risk immigrant populations in middle- and high-income countries: A scoping review

ONYANGO, E., MORI, K., JIREL, B., *et al.*

2025

Social Science & Medicine 380: 118185.
https://doi.org/10.1016/j.socscimed.2025.118185

Pre- and post-migration experiences predispose high-risk immigrants and refugees to elevated risk of food insecurity and negative mental health status. With a significant increase in the occurrence of these challenges in high-risk immigrant populations and the evidence for a syndemic interaction, the need for reasonable efforts and evidence-based interventions to effectively address food insecurity and mental health issues. Such studies could focus on exploring the reinforcing connections between food insecurity and mental health trends. As an initial step to filling in this knowledge gap, we conducted a review of existing literature to explore the commonalities in food security and mental health trends in studies of high-risk immigrants. A systematic search in four major databases (MEDLINE-OVID, CINAHL, Academic Plus, and PubMed) identified 22 relevant articles. A synthesis of these articles identified different subgroups of high-risk immigrants including pregnant women, refugee parents, women immigrants and newcomer youth that experience increased risk of mental health and food insecurity challenges, which are associated with the pre- and post-migration contexts. The experiences of political, social and other environmental violence in countries of origin are traumatic experiences embodied by most high-risk immigrants. On arrival in destination countries, immigrants experience systemic and social barriers that also influence their mental health and food security status. However, access to culturally familiar foods is associated with improved health and wellbeing. Among high-risk immigrants, food, particularly culturally familiar foods are viewed as a symbolic vehicle and a representation of home. When culturally familiar foods are accessible, there is improved mental health status reflected in the ability of immigrants to share their cultures and identity while rebuilding their social networks and enhancing a sense of belonging. Efforts to effectively address food insecurity and mental health challenge in high-risk immigrants require a deep appreciation and understanding of the place and community-based factors and the available resources relevant to the unique needs and experiences of the high-risk immigrant populations.

Internal migration, health selection, and the salmon bias: A register-based study of Finland

PAGLINO, E., ELO, I. T. ET MARTIKAINEN, P.

2025

Social Science & Medicine 380: 118200.
https://doi.org/10.1016/j.socscimed.2025.118200

Studies on international migrants have repeatedly found a mortality advantage of migrant over native-

born populations. Data artifacts, differential prevalence of health-related behaviors, and health-related selection of immigrants and return migrants have been proposed as explanations. Neither the existence of a migrant mortality advantage for internal migrants nor the validity of existing explanations for this group have been extensively studied. Taking advantage of Finnish register data, we extend the literature on health and internal migration in four ways: 1) by using finer geographic units than previous studies, 2) by adopting models that provide more flexibility compared to alternatives based on the proportional hazard assumption, 3) by distinguishing migrants based on whether they return to their birth region (returnees) or do not (leavers), and by age at migration, and 4) by examining cause-specific mortality. We find that both leavers and returnees enjoy a mortality advantage over non-migrants. For both groups, the mortality advantage relative to non-migrants declines with age but is more pronounced for those who move above age 60 and small or negative for those who move at prime working ages. Circulatory-disease mortality accounts for more than half of the longevity advantage of both leavers and returnees. External and alcohol-related causes also contribute, particularly at younger ages. Our results challenge the idea that findings from studies of international migrants can be fully generalized to internal migrants. We demonstrate a consistent healthy migrant effect for all internal migrants, both those who leave and those who return to their region of birth.

Echoes of Inequity: Charting Colombia's stroke mortality shifts and socioeconomic and spatial disparities over two decades

PAULINA, V. G., VIVIANA, M. M., IVONNE ANDREA, O. M., *et al.*

2025

Health & Place 94: 103476.

https://doi.org/10.1016/j.healthplace.2025.103476

Background Stroke remains a significant public health challenge globally and in Colombia, influenced by socioeconomic and demographic factors. Despite declining mortality rates, inequities persist. This study explores trends in stroke mortality in Colombia (1999–2017), focusing on inequalities by age, sex, and educational attainment. Method A descriptive longitudinal retrospective study was conducted using mortality data from the National Administrative Department of Statistics. Standardized Mortality Rates (SMRs) were calculated, adjusting for age and sex. Poisson regression models and the Relative Index of Inequality (RII) assessed inequalities. Geographic analyses examined spatial mortality patterns using Geographic Information Systems. Results Between 1999 and 2017, 262,350 stroke deaths occurred, predominantly in older adults and individuals with lower educational attainment. Stroke mortality declined over time but remained higher among men (66.01/100,000) compared to women (65.74/100,000). Mortality rates were highest in individuals with primary education and lowest in those with tertiary education. Geographic analysis revealed higher mortality in more economically developed regions, suggesting potential underreporting in less developed areas. The RII highlighted pronounced inequalities, especially among women and younger age groups. Conclusions While stroke mortality in Colombia has decreased, marked inequities persist, particularly by educational level and geographic region. Addressing these inequalities requires targeted public health policies to enhance healthcare access and promote equity.

Inequality Measurement for Bounded Variables

PERMANYER, I., SETH, S. ET YALONETZKY, G.

2025

Health Econ 34(8): 1443-1460.

https://doi.org/10.1002/hec.4969

Many health indicators are bounded, that is, their values lie between a lower and an upper bound. Inequality measurement with bounded variables faces two normative challenges well-known in the health inequality literature. One is that inequality rankings may or may not be consistent across admissible attainment and shortfall representations of the variable. The other is that the set of maximum-inequality distributions for bounded variables is different from the respective set for variables with no upper bound. Therefore, the ethical criteria for ranking maximum-inequality distributions with unbounded variables may not be appropriate for bounded variables. In a novel proposal, we justify an axiom requiring maximum-inequality distributions of bounded variables to be ranked equally, irrespective of their means. Then, our axiomatic characterization naturally leads to indices that measure inequality as an increasing function of the observed proportion of maximum attainable inequality for a given mean. Additionally, our inequality indices rank distributions consistently when switching between attainment and shortfall representations. In our empirical illustration with three health indicators, a starkly different picture

of cross-country inter-temporal inequality emerges when traditional inequality indices give way to our proposed normalized inequality indices.

Migration-Induced Subjective Social Mobility and Its Associations with Self-Rated Mental and General Health: A Systematic Review and Narrative Synthesis

PLATZ PEREIRA, M., GOTTLIEB, N., HINTERMEIER, M., *et al.*

2025

Social Science & Medicine 383: 118459.

https://doi.org/10.1016/j.socscimed.2025.118459

ABSTRACT Social mobility affects health, but comprehensive evidence on its health effects in migration contexts is lacking. This systematic review summarizes the global empirical quantitative evidence on the impact of migration-induced subjective social mobility on self-rated health outcomes among first-generation migrants, including internally displaced people, international and internal migrants. A systematic search was performed in three scientific databases, using search terms related to migrants, social status/mobility and health outcomes. Studies were included if migrant populations, quantitative measures of health outcomes and subjective social mobility were reported. In total, 13 records met all criteria, representing five different country contexts and covering international migrants, asylum seekers, refugees, and rural-to-urban migrants. Applying cross-sectional study designs, the main outcomes assessed were general health, subjective well-being/life satisfaction and depression. The overall evidence shows that downward subjective social mobility consistently correlates with negative mental health effects, namely depression, while upward social mobility is associated with better mental health outcomes. Similar tendencies were found for general health and life satisfaction. The results indicate that downward subjective social mobility is associated with poorer general health, lower life satisfaction and higher risk of depression across various contexts. Correspondingly, upward subjective social mobility and social mobility belief is associated with better general health, higher life satisfaction and lower risk of depression. These findings highlight the need for policies that support post-migration socioeconomic integration to prevent or mitigate the experience of downward mobility and its adverse health effects. Future research is needed to better understand pathways and interactions between policies, contexts, and individual trajectories influencing migration-induced social mobility.

The social gradients in mental health and psychosocial well-being from adolescence to midlife and the mediating role of parenting practices: a national cohort study

POTOCAR, L., KOZAK, M., BOE, T., *et al.*

2025

Social Science & Medicine 383: 118405.

https://doi.org/10.1016/j.socscimed.2025.118405

Research investigating social inequalities in mental health and well-being across the life course is scarce. Moreover, a comprehensive examination of underlying pathways linking early life disadvantage to subsequent mental health inequalities is needed. This nationally representative prospective cohort study in Norway followed 3,072 individuals from adolescence (mean age 15 years, 1992) to midlife (43 years, 2020). Using latent growth curve modeling, we examined the magnitude and life course development of social gradients in self-reported internalizing problems (symptoms of depression and anxiety), externalizing problems (problematic alcohol use and conduct problems), and psychosocial well-being (loneliness and self-esteem). Family disadvantage in adolescence was assessed by parental educational attainment and living situation. Parenting practices, including behavioral monitoring, warmth, educational investment, social support, and psychological overcontrol, were examined as mediators. Results showed that living with both biological parents was consistently linked with better mental health and psychosocial well-being, with these advantages persisting into midlife. In contrast, lower parental educational attainment was associated with deteriorated psychosocial well-being and externalizing problems during adolescence, but these inequalities diminished with age. Importantly, individuals from advantaged families experienced more nurturing, supportive, and involved parenting, which accounted for a substantial portion of observed mental health disparities during adolescence. Altogether, our findings highlight the importance of early social disadvantage for mental health and well-being across the life course, underscoring the critical role of parenting practices in shaping these trajectories.

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

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

2025

Social Science & Medicine 380: 118176.
https://doi.org/10.1016/j.socscimed.2025.118176

Low-wage labour migrants often face health-damaging living and working conditions, but are frequently excluded from healthcare. The othering of migrants, bordering of healthcare and simple oversight and negligence create widening health inequalities for a society's essential workers. This review aimed to identify the forms and effectiveness of healthcare services designed to make healthcare accessible for migrant workers. We searched for literature through Medline, Embase, Global Health, Web of Science, and Global Index Medicus (from 1 January 2000 till 9 June 2023), focussing on selected work sectors (domestic work, construction, manufacturing, agriculture, mining). Primary research, reports, and grey literature from 2000 onwards containing descriptions or evaluations of healthcare services exclusively targeting low-wage migrant workers and their families were included. We excluded services focussing only on specific health conditions or disease screening. Quality appraisal was based on tools from the Joanna Briggs Institute. We narratively synthesised service characteristics and effects. This review follows the PRISMA reporting guidelines for systematic reviews and is registered with PROSPERO (CRD42023459360). Identified studies included 21 healthcare services targeting low-wage migrant workers in six countries (China, Dominican Republic, Italy, Qatar, South Africa, USA) in three sectors (agriculture, manufacturing, domestic work). Services included established medical facilities (e.g., general hospital care, semi-permanent primary healthcare (PHC) services); mobile clinics for PHC; and telehealth services. The healthcare services were provided by governmental, non-governmental, academic, and private actors. Most targeted migrant farmworkers and were primarily located in the United States. Common healthcare barriers were addressed, for example, via free care, outreach, or non-traditional hours. However, service effects on health, access and uptake, patient satisfaction, and acceptability were largely unclear, as only six studies offered some fragmentary evaluative evidence. Few healthcare services targeting migrant workers have been documented and evaluated, especially in LMICs. Although migrant workers are deemed to be mobile populations, once in the destination location, many are quite immobile when it comes to accessing healthcare. Thus, in the face of persistent exclusion of migrant workers, health systems cannot simply rely on the ability of this vital workforce to seek and use preventative or curative care, but healthcare services must be actively designed to be accessible to this mobile population in order to ensure health as a human right.

Left behind? A longitudinal ecological study of 'regional deprivation amplification' and life expectancy growth in England (2004 to 2020)

SIMPSON, J., ALBANI, V., MUNFORD, L., *et al.*

2025

Health & Place 94: 103478.
https://doi.org/10.1016/j.healthplace.2025.103478

Geographical inequalities in health are substantial and increasing in many countries. In England, there is a life expectancy gap amongst the 20 % most deprived local authorities – between those in the northern regions and those in the rest of the country. We sought to quantify the size and evolution of this gap and to investigate potential contributing factors. We used data from official national statistics covering years 2004–2020 for the 20 % most deprived local authorities in England, divided into north and rest of England. We conducted a Blinder-Oaxaca decomposition which quantified the size of the life expectancy gap for both men and women and identified the key contributing factors drawing on 'deprivation amplification' concept and other theories of health inequalities. We have found that there is a long-standing and widening gap in life expectancy between local authorities in the north and the rest of England. The gap is greater for women than for men (11.7 vs. 7.0 months on average); the widening of the gap over the past two decades has also been greater for women. Our decomposition analysis indicates that regional differences in income are the main contributor to this gap for both men and women (explaining 69 % and 44 % of the gap, respectively), with behavioural factors such as smoking having no explanatory power. Overall, our findings suggest that providing additional income-based resources to areas lagging behind in life expectancy may be an effective way of reducing place-based health inequalities both in England and in similar regionally imbalanced economies.

Inequality of Opportunity in Body Mass: Evidence From Australia

VIJAYASIVAJIE, A., MUKHOPADHAYA, P. ET HEATON, C.

2025

Health Econ 34(7): 1365-1381.

https://doi.org/10.1002/hec.4966

This paper extends current knowledge about inequality of opportunity in body mass in Australia. Drawing on 2013 and 2017 Household, Income, and Labour Dynamics in Australia survey data, our empirical strategy comprises of mean-based and unconditional quantile regression techniques. We find that inequality of opportunity accounts for a non-trivial share of body mass inequality. Our results based on waist-to-height ratio reveal estimates of 10%-14%, which are much larger than previously published estimates based on body mass index (BMI). Our estimates are lower-bound values based on 13 observable circumstance variables. Relaxing the homogeneity assumption, for instance, increases estimates by 1.7-3 percentage points. Applying the Shapley-Shorrocks decomposition procedure, age and parents' socio-economic status are identified as leading circumstance factors. This finding is refined when quantiles of the body mass distribution are evaluated. Age's role is diminished at the clinically risky upper quantiles. By contrast, parents' socio-economic status is the single most important circumstance factor at the upper quantiles. Investigating by gender groups, inequality of opportunity is greater among women than men, with parents' socio-economic status playing a critical role in this disparity. Taking a life course perspective, circumstances' influence shows weakening over time, while effort is more impactful at later life stages. Overall, our findings underscore that anti-obesity campaigns should tackle early life social inequality, in addition to empowering personal responsibility later in life.

Behavioural and metabolic mediators of socioeconomic inequalities in type 2 diabetes: comparing counterfactual and traditional mediation analysis

YACAMAN MENDEZ, D., TROLLE LAGERROS, Y., PONCE DE LEON, A., *et al.*

2025

European Journal of Public Health 35(4): 605-610.

https://doi.org/10.1093/eurpub/ckaf056

There is a well-established social gradient in the occurrence of type 2 diabetes, but the extent to which behavioural or metabolic risk factors explain these inequalities remains unclear. Leveraging data from 7123 adults and over 20 years of follow-up, we used counterfactual mediation analysis to estimate the direct effect of low socioeconomic status (measured as educational attainment and occupational class) on the risk of type 2 diabetes, and the indirect effect through behavioural and metabolic risk factors. Mediators included were smoking, high alcohol consumption, low physical activity, diet low in vegetables or fruits, high body mass index (BMI), high fasting glucose, and hypertension. We compared the results to mediation analysis using the difference and the product of coefficients methods. We found an association between low educational attainment 1.31 (95% CI 1.16, 1.45) and low occupational class 1.24 (95% CI 1.09, 1.38) with future risk of type 2 diabetes. In the counterfactual mediation analysis, behavioural and metabolic risk factors explained 60% (95% CI 41%, 75%) of the effect of low educational attainment and 42% (95% CI 19%, 65%) of the effect of occupational class on the risk of type 2 diabetes. The difference and product of coefficients methods yielded similar results. Well-established behavioural and metabolic mediators explained roughly half of the health inequalities in the incidence of type 2 diabetes. Public health interventions should consider alternative mechanisms to reduce disparities in the incidence of type 2 diabetes.

Hospital admissions for undocumented immigrants: a comparative analysis of French healthcare coverage schemes

ZARCA, K., BEKKAR, Z., RAPP, T., *et al.*

2025

European Journal of Public Health 35(4): 687-692.

https://doi.org/10.1093/eurpub/ckaf113

Disparities in healthcare access persist in European countries for undocumented immigrants and are influenced by political issues. In France, healthcare access for this population is divided between two programs: the State Medical Aid (SMA), which provides broad healthcare coverage, and the Urgent and Vital Care (UVC) program, which is limited to life-threatening conditions for those ineligible for SMA or other assistance. Analyzing hospital admissions and costs related to these programs can provide insights into the implications of restricted healthcare access. This retrospective cohort study used data from the French national hospitalization database between 2013 and 2021. All hospi-

tal stays involving undocumented immigrants covered under either the SMA or UVC programs were included. The primary outcome was the average cost per hospital stay for each program. Secondary outcomes included length of stay (LOS) and use of intensive care unit (ICU). Multivariable generalized linear mixed models were employed to adjust for patient and hospitalization characteristics. The study included 197 327 patients under SMA and 40 322 under UVC. Emergency department admissions accounted for 47% of SMA hospitalizations compared to 68% for UVC. The average cost per SMA stay was €3758 (95% CI, €3637–€3883), which was 13% lower than UVC stays (average absolute difference, AAD: €504). UVC patients had a 16% higher probability of ICU admission (AAD: 1.08 days in ICU) and a 19% higher total LOS compared to SMA patients. Undocumented immigrants without comprehensive healthcare coverage under SMA incur higher hospital costs, longer stays, and increased ICU admission rates than those covered by SMA.

Médicaments

Pharmaceuticals

▶ The revision of the EU pharmaceutical legislation: policy content analysis

GAMBA, S., MAGAZZINI, L. ET PERTILE, P.

2025

Health Policy 161: 105408.

https://doi.org/10.1016/j.healthpol.2025.105408

A revision of the pharmaceutical legislation is ongoing at the European Level. The European Commission proposed a first draft in April 2023, and the European Parliament has adopted a position on the proposal in April 2024. The proposal consists of a new Directive and a new Regulation, with the aim of integrating different provisions that have been introduced over time. The proposal aims at encouraging the industry in conducting research and developing technologies that reach patients, while addressing market failures. We discuss both general and targeted incentives that are proposed, as well as the provisions to foster access to medicines for all patients in the European Union. Although the legislative process has not been completed yet, an analysis of the texts that have been debated so far, vis-à-vis the legislation in force, can inform on the most relevant and debated issues and on the aspects the reform is most likely to affect.

▶ Drug deprescribing policy and incentives in France

MEGERLIN, F., BOUVENOT, G. ET QUENEAU, P.

2025

Annales Pharmaceutiques Françaises 83(5): 933-940.

https://doi.org/10.1016/j.pharma.2025.04.003

Résumé La déprescription de médicaments (devenus) inappropriés est partout un enjeu de santé publique, notamment dans les pays de forte polymédication. Malgré l'introduction du terme « déprescription » en France dès 2002 et les recommandations de pratique clinique, ses progrès en secteur ambulatoire ont été limités. Notre article décrit les incitations financières adoptées par conventions nationales entre l'Assurance maladie (assureur santé obligatoire en France) et les syndicats de praticiens indépendants : les pharmaciens sont incités à établir et partager des bilans de médication (depuis 2018, population cible étendue en 2022). Mais les résultats ayant été modestes, les médecins sont depuis 2024 financièrement incités à proposer des consultations médicales dédiées à la déprescription, et à prescrire des bilans de médication par les pharmaciens. Cet article décrit le nouveau cadre en droit en secteur ambulatoire et hospitalier, et invite à en étudier les effets attendus dès 2025 sur les bases de données nationales grâce au codage pour le paiement de nouveaux services.

▶ Alternative Payment Models for Innovative Medicines: A Framework for Effective Implementation

MCELWEE, F., COLE, A., KALIAPPAN, G., *et al.*

2025

Applied Health Economics and Health Policy 23(4): 535-549.

https://doi.org/10.1007/s40258-025-00960-1

Scientific advancements offer significant opportunities for better patient outcomes, but also present new challenges for value assessment, affordability and access. Alternative payment models (APMs) can offer solutions to the ensuing payer challenges. However, a comprehensive framework that matches the spectrum of challenges with the right solution, and places them within a framework for implementation, is currently missing. To fill this gap, we propose evidence-based steps for the effective selection and implementation of APMs. First, contracting challenges should be identified and mapped to potential APM solutions. We developed a decision guide that can serve as a starting point to articulate core problems and map these to APM solutions. The main problem categories identified are: budget impact and uncertainty, value uncertainty, and the scope of value assessment and negotiation. Subcategories include affordability, uncertainty of effectiveness, and patient heterogeneity, which map onto APM solutions such as outcome-based agreements, instalments, and subscription models. Just as important are the subsequent identification and assessment of the feasibility of potential solutions as well as collaboration to reach agreement on the terms of the APM and lay the groundwork for effective implementation. We adduce recent examples of APM implementation as evidence of how commonly cited implementation barriers can be overcome by applying pragmatic design choices and collaboration. This step-by-step framework can aid payers and manufacturers in the process of effectively identifying, agreeing on, and implementing APMs to advance patient access to cost-effective medicines, while at the same time providing appropriate incentives to support future innovation.

Impact of the 2012 Pharmaceutical Co-payment Reform on Drug Consumption Among Children in Catalonia: Evidence from a Regression Discontinuity Design

MORA, T.

2025

Health Policy 161: 105413.

https://doi.org/10.1016/j.healthpol.2025.105413

Background Poor childhood health negatively affects health and socioeconomic status later in life. One crucial policy tool is the modification of co-payment conditions, which can cause parents to experience more rigid budget constraints and cause reductions in the number of prescription drugs given to their children. Objective This study estimates the price sensitivity of prescription drug demand using data on all prescription drug purchases for the non-adult population in Catalonia from 2010 to 2015. Methods We use a sharp regression discontinuity design (RDD) with no bandwidth, exploiting 2012 reforms in Catalonia (Spain). Results Our results indicate overall reductions in the defined daily dose (DDD) consumption over three years post-reform for children of parents who experienced increases in their co-payment levels (8.1% for a 10% increase). In contrast, those whose parents did not experience a reduction in co-payment rates had a 7.0 percentage point increase in the number of prescriptions used. We corroborated our findings by considering drug stockpiling. Interestingly, prescriptions related to females showed higher reductions than those for males. Disentangling drug consumption by type of condition, we show that drug purchases related to respiratory health conditions experienced smaller reductions and, more specifically, the ones associated with asthma, compared to mental health diseases such as Attention-Deficit/Hyperactivity Disorder. Conclusions We evidence significant changes in overall drug consumption for young people in Spain following the reforms of co-payments.

Understanding physician prescription behaviors: a systematic review and meta-analysis of macro, meso, and micro-level influences

MORETTI, G., FERRE, F., MARTELLI, A., *et al.*

2025

Health Policy 161: 105415.

https://doi.org/10.1016/j.healthpol.2025.105415

Background Prescription is a complex act that reflects the physician's expertise and authority. While some factors affecting prescription decisions have been studied, empirical findings often conflict, leaving our understanding of prescription behaviors limited and fragmented. Objective To assess the factors influencing physicians' drug prescribing habits by applying Strong Structuration Theory. Factors are categorized at: physician, practice, patient, industry, and system level. Methods Pubmed, Scopus, and ISI Web of Science were searched from inception to June 2025. Peer-reviewed studies were included if they were published in English, empirical, and assessed at least one factor influencing physicians' prescribing behaviors. Studies reporting the effect of covariates on prescriptions using Odds Ratios were included in the meta-analysis. Results 146 studies were included in the review. At the macro-level, physicians were more likely to prescribe after being exposed

to marketing activities by pharmaceutical industries, and for privately insured patients. Meso-level factors, such as practice ownership and setting, showed conflicting results, with no significant effect observed in the meta-analysis. Micro-level influences were the most prevalent in literature. Patient requests had a significant positive effect on prescriptions. Physician-level influences were inconsistent across most variables, except gender, where male physicians were more likely to prescribe. This effect was not confirmed by the meta-analysis, which showed heterogeneity across studies. Conclusion This study highlights the complexity of prescribing behaviors and the challenges in designing effective micro-level policies. Policymakers should therefore consider the multiple influences on prescribing to design targeted interventions that promote rational prescribing practices.

Méthodologie - Statistique

Methodology-Statistics

▶ Identification du seuil d'activité du médecin généraliste au sein de la base de données du Système-national-d'information-interrégimes-de-l'assurance-maladie (SNIIRAM) : un apport méthodologique

KANANOVICH, K., DE FONTGALLAND, C., MÉNORET, F., *et al.*

2025

Journal de gestion et d'économie de la santé 1(1): 3-21.

https://doi.org/10.54695/jdds.043.1.0003

Introduction : Identifier le médecin généraliste parmi les omnipraticiens recensés dans le SNIIRAM est une tâche impérative pour permettre une meilleure planification de la démographie médicale. La création d'un indicateur synthétique est possible en analysant certaines données liées à l'activité de ces offreurs de soins de premières lignes (forfaits médecin traitant, part des actes cotés G ou CCAM, niveau d'activité, etc.). Méthodes : L'analyse statistique du fichier des omnipraticiens de la région Centre en 2022 (extrait du SNIIRAM et d'ERASME) permet de déterminer des variables identifiant formellement les médecins généralistes. Convertir l'activité de ces professionnels de santé en construisant un indicateur plus pertinent entraîne une meilleure appréciation de la réelle offre de soins de premier recours. Ces résultats ont été confirmés par un travail qualitatif auprès d'un échantillon robuste de médecins. Résultats : 1 731 médecins sont recensés comme omnipraticiens par le SNIIRAM. Parmi eux, seuls 1 531 ont été identifiés comme médecin généraliste, représentant une force de travail de 1 577 médecins. Cela représente donc une baisse de plus de 8,8 % entre l'offre supposée et l'offre effective de soins, dans une région qui connaît déjà la plus faible densité en médecins généralistes de France Métropolitaine. Conclusions : Ce travail a permis de caractériser avec précision l'offre de soins de premier recours en région Centre-Val-de-Loire, et de proposer un zonage conventionnel médecin basé sur l'offre de soins réelle, au plus proche du terrain, des difficultés des professionnels et des patients.

▶ Qualitative methods and the commercial determinants of health: Insights from the social sciences

GOMEZ, E. J.

2025

Social Science & Medicine 380: 118168.

https://doi.org/10.1016/j.socscimed.2025.118168

While the commercial determinants of health (CDoH) is a growing field of study, insufficient attention has been paid to developing its qualitative methodological and theoretical contributions. CDoH researchers may benefit from considering the social science community's usage of qualitative methodological tools such as case studies for theory development, causal mechanisms and process-tracing for improved causal inference. While CDoH researchers have become interested in quantitative methods and establishing indicators and datasets for comparative statistical analysis, this article finds limitations with this approach and suggests that researchers focus first on establishing ample case study qualitative evidence with the eventual goal of

devising theory-informed quantitative indicators and datasets. The timing is propitious for CDoH researchers and social scientists to work together to strengthen CDoH's methodological and theoretical contributions.

Towards effective policy measures to reduce informal payments in healthcare: addressing sample selection bias and measurement error in surveys

AREZZO, M. F., GUAGNANO, G., WILLIAMS, C. C., *et al.*

2025

Health Policy 159: 105367.
https://doi.org/10.1016/j.healthpol.2025.105367

Previous research has primarily utilized surveys to assess the extent of informal payments, identify key drivers, and recommend policy interventions. However, reliance on surveys presents challenges, including representativeness issues and social desirability bias, which may result in underestimated prevalence and misinformed policy measures. The aim of this paper is to evaluate the influence of these biases on estimating the prevalence of informal payments and on the development of effective policies to reduce informal payments. Reporting data from the third wave of Life in Transition Survey conducted in 2016 across 34 countries, a significant misalignment between reported and (estimated) actual behaviours regarding informal payments was found. The results of a Probit model adjusted for sample selection and measurement error revealed that, among those who made informal payments, approximately 20% of respondents declared the opposite while the global prevalence of individuals making informal payments in the analysed countries is approximately 18%. The implications for policy measures towards informal payments in public healthcare are then discussed.

The Role of Burden of Disease Estimates in European Union Health Policymaking: A Systematic Analysis of EU Legislation

CHEN-XU, J., GRAD, D., MAHROUSEH, N., *et al.*

2025

Health Policy 159: 105387.
https://doi.org/10.1016/j.healthpol.2025.105387

Background The use of burden of disease (BoD) metrics in policymaking is crucial for evidence-based decision-making. However, there is currently no information available regarding their utilisation in policies at the European level. Objective This study aimed to analyse the use of BoD metrics within the European legislation. Methods Systematic searches on EUR-Lex were conducted for documents published between 2004 and 2023, to account for European Union-25 (EU-25). Network and qualitative analyses of documents were conducted to assess the legislation content. Results In total, 2615 documents were found, of which 191 included BoD metrics. Among the selected documents, 131 (69%) were published after 2018. Ten were legally binding documents. The most prevalent EuroVoc (EU's multilingual and multidisciplinary thesaurus) domains were social questions and environment. The most frequent EuroVoc terms were climate change policy (n=45), EU environmental policy (n=32) and pollution control measures (n=32). The most common EU institution responsible for the retrieved documents was the European Commission (n=152). As for the purposes of usage, argument (n=93) and impact assessment (n=50) were most common. Most BoD metrics were localized in the main text (n=122). Conclusion Despite growing recognition of BoD metrics in supporting policymaking, their use remains focused on environmental health topics. Further efforts in training policymakers, knowledge dissemination and policy-oriented research could enhance the uptake of BoD studies in EU policies.

The second Health Inequalities Module in the European Social Survey (ESS): Methodology and research opportunities

HOVEN, H., EIKEMO, T. A., BACKHAUS-HOVEN, I., *et al.*

2025

Social Science & Medicine 380: 118228.
https://doi.org/10.1016/j.socscimed.2025.118228

The European Social Survey (ESS) is a pan-European social survey that has mapped and explained stability and change in the attitudes, beliefs, and behaviour patterns of European populations since 2002. In 2013/14, the ESS introduced a rotating module on health and its social determinants. With this Health Inequalities module, the ESS contributed substantially to social epidemiological research and inquiry into social inequalities in health and it became a vital data source for public health research, advancing knowledge of why social inequalities in health exist in Europe and how they vary between countries and welfare states. With the second rotating Health Inequalities module in 2023/24, the ESS enables new research opportunities, primarily by generating robust and cross-national comparative data on

stability and change of social inequalities in health in times of various economic, demographic, public health, and political developments. The aims of the current paper are threefold. First, we summarize key insights on health inequalities in Europe provided by data from the first ESS Health Inequalities Module. Second, we describe the methodology of the second ESS Health Inequalities Module. Third, we point to future research opportunities and offer some critical reflections. By describing in detail the analytical opportunities that the two ESS Health Inequalities Modules provide, we aim to increase engagement with the survey from a wide range of health-focused disciplines including anthropology, geography, health economics, psychology and sociology.

A Framework for Reliable, Transparent, and Reproducible Population-Adjusted Indirect Comparisons

ISHAK, K. J., CHANDLER, C., LIU, F. F., *et al.*

2025

PharmacoEconomics 43(7): 691-710.

https://doi.org/10.1007/s40273-025-01503-1

Population-adjusted indirect comparison (PAIC) methods aim to address some of the potential shortcomings of conventional approaches to indirect treatment comparisons by adjusting for imbalances in effect modifiers or prognostic factors and allowing for unanchored indirect treatment comparisons from disconnected networks of evidence. Health technology assessment bodies have published guidance and best practice recommendations for PAICs. However, recently published reviews of published PAICs have highlighted notable variability in implementation and a lack of transparency in the decision-making process in analyses and reporting; this hinders the interpretation and reproducibility of analyses, which, in turn, could affect reimbursement decision-making. We propose a systematic framework to address these challenges by describing considerations on six key elements of analyses: (1) definition of the comparison of interest (e.g., in terms of an estimand), (2) selection of the PAIC method, (3) selection of adjustment variables, (4) application of adjustment method, (5) risk-of-bias assessment, and (6) comprehensive reporting.

Attentional processes underlying health state valuation with time trade-off and standard gamble tasks

LIPMAN, S. A. ET PACHUR, T.

2025

Journal of Health Economics 102: 103026.

https://doi.org/10.1016/j.jhealeco.2025.103026

Time Trade-Off (TTO) and Standard Gamble (SG) tasks are commonly used methods to measure utilities for health states (e.g., diabetes, being in a wheelchair). Importantly, however, the two methods have been shown to typically yield discrepant utilities for a given health state. Here we examine the cognitive processes underlying this utility gap by analyzing individuals' attentional patterns during the TTO and SG tasks. In an online experiment (each respondent completed both a TTO and an SG task), we used the process-tracing methodology Mouselab to record respondents' attention allocation to the tasks' attributes: health states, duration, and probabilities. In the TTO task, attention was approximately balanced between the health state and duration attributes, whereas in the SG task, attention was shifted to a focus on probabilities and the health state attribute. Individuals who paid more attention to the task-specific trade-off attribute (i.e., duration and probability in TTO and SG, respectively) seemed to be less willing to make those trade-offs, leading to higher utilities for the health states. Notably, the utility gap was associated with individual differences in attention allocation: respondents who adjusted their attention allocation less to the task-specific trade-offs produced more discrepant utilities between the TTO and SG tasks. Our findings underscore the key role of attentional processes in preference construction, highlighting that differences in the utilities people assign to health states could potentially be altered by affecting attention allocation.

How to incorporate social vulnerability into epidemic mathematical modelling: recommendations from an international Delphi

NAIDOO, M., SHEPHARD, W., MTSHALI, N., *et al.*

2025

Social Science & Medicine 383: 118352.

https://doi.org/10.1016/j.socscimed.2025.118352

Epidemic mathematical modelling plays a crucial role in understanding and responding to infectious disease epidemics. However, these models often neglect social

vulnerability (SV): the social, economic, political, and health system inequalities that inform disease dynamics. Despite its importance in health outcomes, SV is not routinely included in epidemic modelling. Given the critical need to include SV but limited direction, this paper aimed to develop recommendations that researchers can use to incorporate SV in epidemic mathematical modelling. Using the Delphi technique, 22 interdisciplinary experts from 12 countries were surveyed to reach consensus on research recommendations. Three rounds of online surveys were completed, consisting of free-text and seven-point Likert scale questions. Descriptive statistics and inductive qualitative analyses were conducted. Consensus was reached on 27 recommendations across seven themes: collaboration, design, data selection, data sources, relationship dynamics, reporting, and calibration and sensitivity. Experts also identified 92 indicators of SV with access to sanitation (n=14, 6.1%), access to healthcare (n=12, 5.3%), and household density and composition (n=12, 5.3%) as the most frequently cited. Given the recent focus on the social determinants of pandemic resilience, this study provides both process and technical recommendations to incorporate SV into epidemic modelling. SV's inclusion provides a more holistic view of the real world and calls attention to communities at risk. This supports forecasting accuracy and the success of policy and programmatic interventions.

Predicting Health Utilities Using Health Administrative Data: Leveraging Survey-linked Health Administrative Data from Ontario, Canada

NIU, Y., BEGEN, N., ZOU, G., *et al.*

2025

Applied Health Economics and Health Policy 23(4): 661-677.

https://doi.org/10.1007/s40258-025-00947-y

The quality-adjusted life year (QALY) is widely used to measure health outcome that combines the length of life and health-related quality of life (HRQoL). To be a reliable QALY measure, HRQoL measurements with a preference-based scoring algorithm need to be converted into health utilities on a scale from zero (dead) to one (perfect health). However, preference-based health utility data are often not available. We address this gap by developing a predictive model for health utilities.

Decomposing Variations on Cluster Level for Binary Outcomes in Application to Cancer Care Disparity Studies

UNO, H., TRAMONTANO, A. C., PUNGLIA, R. S., *et al.*

2025

Health Services Research 60(4): e14599.

https://doi.org/10.1111/1475-6773.14599

ABSTRACT Objective To develop a method to decompose the observed variance of binary outcomes (proportions) aggregated by regional clusters to determine targets for quality improvement efforts to reduce regional variations. Data Sources and Study Setting Data from the 2018 linkage of the Surveillance, Epidemiology, and End Results–Medicare database. Study Design We developed a method to decompose the observed regional-level variance into four attributions: random, patients' characteristics, regional cluster, and unexplained. To demonstrate the efficacy of the method, we conducted a series of numerical studies. We applied this method to our cohort to analyze endocrine therapy receipt 3–5 years after diagnosis, using health service area (HSA) as the regional cluster. Data Extraction Methods Our cohort included Stages I–III breast cancer patients diagnosed at ages 66–79 between 2007 and 2013 who received cancer surgery and were enrolled in Medicare Parts A and B. Principal Findings After decomposition, 39% of the total variation was explained by HSAs, which was higher than that in some other breast cancer measures, such as the proportion of Stage I at diagnosis (4%), previously reported. This suggests geospatial efforts have a great potential to address the regional variation regarding this measure. Conclusions Our variance decomposition method provides direct information about attributable variance in the proportions at a cluster level. This technique can help in the identification of intervention targets to improve regional variations in the quality of care and clinical outcomes.

Regression and decomposition with ordinal health outcomes

WU, Q. ET KAPLAN, D. M.

2025

Journal of Health Economics 102: 103012.

https://doi.org/10.1016/j.jhealeco.2025.103012

Although ordinal health outcome values are categories like "poor" health or "moderate" depression, they are often assigned values 1,2,3,... for convenience. We provide results on interpretation of subsequent analysis

based on ordinary least squares (OLS) regression. For description, unlike for prediction, the OLS estimand's interpretation does not require that the 1,2,3,... are cardinal values: it is always the "best linear approximation" of a summary of the conditional survival functions. Further, for Blinder–Oaxaca-type decomposition, the OLS-based estimator is numerically equivalent to a certain counterfactual-based decomposition of the survival function, again regardless of any cardinal values. Empirically, with 2022 U.S. data for working-age adults, we estimate a higher incidence of depression in the rural population, and we decompose the rural–urban difference. Including a nonparametric estimator that we describe, estimators agree that 33%–39% of the rural–urban difference is statistically explained by income, education, age, sex, and geographic region. The OLS-based detailed decomposition shows this is mostly from income.

Politique de santé

Health Policy

▶ Provider Perspectives on Implementation of Adult Community-Based Palliative Care: A Scoping Review

DUSSAULT, N., HO, D., DUKKIPATI, H., *et al.*

2025

Medical Care Research and Review 82(4): 301–318.

https://doi.org/10.1177/10775587241303963

While community-based palliative care (CBPC) programs have been expanding, there remain important obstacles to widespread use. Since provider perspectives on CBPC remain underexplored, we conducted a scoping review to summarize provider perspectives...

▶ Organizational Health Literacy: A scoping review of the current landscape and a framework proposal for preventive medicine through intersectoral collaboration

FERREIRA-ALFAYA, F. J., CURA, Y. ET JOSE ZARZUELO-ROMERO, M.

2025

Health Policy 159: 105380.

https://doi.org/10.1016/j.healthpol.2025.105380

Background Organizational Health Literacy (OHL) refers to the extent to which organizations facilitate equitable access, comprehension, and use of health information and services for informed decision-making. Objective This study aimed to (1) review and map existing OHL frameworks and (2) propose an innovative OHL framework that addresses gaps identified in current models. Methods A systematic search of academic (Web of Science, Scopus, MEDLINE) and grey literature from the past 15 years was conducted to identify OHL frameworks. This scoping review followed the PRISMA-ScR guidelines and the Arksey and O'Malley model. A new OHL intervention framework was developed to address gaps in existing models, based on the principles of preventive medicine and the public health action cycle. Results A total of 19 records were included (10 from academic databases and 9 from grey literature), covering diverse approaches and contexts related to OHL. Four intervention levels were identified: integrating HL into formal education, implementing HL assessments, developing interventions for vulnerable populations, and enhancing accessibility to health resources. The proposed framework emphasizes intersectoral collaboration and communication pathways between education and healthcare sectors, facilitating information exchange to continuously adapt interventions to population needs. Conclusion OHL development requires intersectoral collaboration; however, interoperability between sectors remains unaddressed in existing frameworks. This study proposes an innovative model that fosters sectoral connections toward a shared goal, creating a truly collaborative framework.

▶ Policy makers must adopt agile signal detection tools to strengthen epidemiological surveillance and improve pandemic preparedness

MAHE, C., KANNT, A. ET AIOLOS CONSORTIUM

2025

Health Policy 159: 105386.

https://doi.org/10.1016/j.healthpol.2025.105386

The SARS-COV2 pandemic has highlighted the urgent need for agile and responsive disease surveillance systems. To strengthen epidemiological surveillance and improve pandemic preparedness, policymakers must adopt real-time signal detection tools that integrate multisource data, including non-traditional health data, advanced analytics, and artificial intelligence (AI). Such approaches enable more efficient monitoring and decision-making through collaborative networks. Expanding these agile tools across Europe under a supranational mandate would enhance public health outcomes, support healthcare system efficiency, and increase business resilience. Leveraging private sector data and ensuring modularity for gradual scale-up are essential to maintaining adaptability and responsiveness.

Politique sociale

Social Policy

▶ Does Publicly-Funded Adult Social Care Impact Informal and Unpaid Carers' Quality of Life in England?

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

2025

Health Econ 34(7): 1217-1238.

https://doi.org/10.1002/hec.4957

Informal carers are important for their care recipients, but the burden of care may have a detrimental effect on the carer's well-being. Publicly-funded Adult Social Care (simply, ASC) in England may alleviate this burden. We therefore investigate whether ASC expenditure improves carers' quality of life and the channels through which this effect may exist. We analyze data on informal carers from the biennial Survey of Adult Carers in England in 2014/15, 2016/17, 2018/19 and 2021/22. We implement panel data instrumental variables methods that use conditionally exogenous variability in the local taxation to identify the causal effect of ASC expenditure. Our main finding suggests that a pound1000-increase in ASC expenditure per client increases, on average, the carer-reported quality of life score by 0.3, which amounts to 4.2% of its average in 2021/22. Moreover, ASC expenditure has a beneficial impact on informal carers' care tasks, health, range of employment choices, and finances.

Prévention

Prevention

▶ Harnessing financial incentives for health promotion: A scoping review of prevention programs implemented in upper-middle and high-income countries

PETRACCA, F., ARDITO, V., SALA, F., *et al.*

2025

Social Science & Medicine 383: 118499.

https://doi.org/10.1016/j.socscimed.2025.118499

The recent demographic and epidemiological trends, coupled with escalating healthcare costs, necessitate innovative strategies for health promotion and disease prevention. Financial incentives have gained attention as potential tools to encourage desirable health behaviors. This study aims to map real-world programs employing financial incentives for health promotion implemented by public institutions or insurance companies in upper-middle and high-income countries, focusing on program characteristics, incentive structures and available impact assessments. Using a scoping review methodology, we identified 27 programs spanning tax-funded and insurance-based healthcare

systems. Most programs targeted primary prevention, incentivizing behaviors such as vaccination and physical activity, with several multidimensional initiatives addressing multiple health behaviors simultaneously. Incentives ranged from cash payments to vouchers, often linked to measurable outcomes like vaccination completion or activity levels monitored through wearables. The collected evidence suggests these programs can positively influence targeted behaviors. At the same time, solid impact evaluations were lacking for a relevant number of programs in scope, cost-effectiveness estimates remain limited, and the long-term sustainability of behavior change after incentives are removed or reduced calls for additional real-world investigation. This study was the first to analyze the characteristics of real-world implementations of health promotion programs based on financial incentives, complementing existing evidence from experimental studies. Insights from this review can inform the design of more effective and possibly sustainable programs, emphasizing the role of financial incentives in fostering personal responsibility for health while supporting the sustainability of healthcare systems.

▶ Développer la culture de prévention : solution face à une crise systémique ?

CHAUVIN, F. ET COLLANGE, F.

2025

Bulletin de l'Académie Nationale de Médecine 209(7): 967-974.

https://doi.org/10.1016/j.banm.2025.02.016

Résumé La prévention est apparue récemment dans les politiques publiques de santé au point d'être introduite dans l'intitulé du ministère en 2022. Cette appellation, qui disparaîtra en 2024, traduisait la volonté de la France à engager une évolution de son système de santé. Les différents ministres de la santé ont fait le diagnostic d'une crise qui s'aggrave progressivement au point de devenir systémique. La population française vieillit et le taux de dépendance démographique augmente progressivement interrogeant la soutenabilité du système. Malgré des dépenses atteignant 12 % du PIB, l'espérance de vie en bonne santé n'a que très peu augmenté en 20 ans, le nombre de patients porteurs de maladies chroniques est supérieur à 24 millions soit 35 % de la population française et les inégalités en santé progressent avec un gradient social très marqué. Une part importante de ces maladies chroniques est accessible à des actions de prévention permettant de diminuer l'incidence ou de retarder leur apparition. Pour être efficaces, ces interventions doivent respecter un certain nombre de conditions : reposer sur un cadre théorique, mobiliser des modèles de changement, agir simultanément sur les individus et les environnements, être évaluées. Ce sont les conditions pour mettre en œuvre une réelle politique de prévention cohérente susceptible d'augmenter l'espérance de vie en bonne santé, soulager le système de soins et assurer la soutenabilité du système de santé français.

▶ Intergenerational transmission of preventive health-seeking behaviors: Like mother, like daughter? The case of cancer screening in France

DUGORD, C. ET FRANC, C.

2025

Social Science & Medicine 381: 118148.

https://doi.org/10.1016/j.socscimed.2025.118148

One of the driving forces behind the persistence of social health inequalities is the intergenerational transmission of health, which occurs through both hereditary and environmental factors. Within this second pathway, the literature has primarily focused on the transmission of lifestyle-related health behaviors. This study expands on these mechanisms by focusing on the intergenerational transmission of preventive health-seeking behaviors, specifically cervical and breast cancer screenings. We used data from the French E3N-Generations cohorts, which, despite being highly selected, uniquely track several generations of women over a long period. Our analysis draws on surveys conducted at the mothers' level between 1990 and 2014, and on a survey at the daughters' level launched in 2018. We employed conditional mixed process models to estimate the association between mothers' mammogram use (n=6,386) and their daughters' likelihood of regularly undergoing mammograms and Pap smears (n=7,012), while controlling for additional explanatory channels such as risk, socioeconomic status, and territorial context. Daughters whose mothers reported mammogram use across all survey waves, compared to none, were 8.4pp [4; 12pp] more likely to have a Pap smear at least every three years, and 17pp [12; 22pp] more likely to have a mammogram every two years, suggesting a transmission of preventive health-seeking behaviors. Thus, interventions aimed at increasing screening rates among women with lower engagement in preventive care could benefit both current and future generations, helping to break the cycle of social health inequalities.

Impacts of health checkup programs standardization on working-age self-employed and unemployed: Insights from Japan's local government response to national policy

OIKAWA, M., OTAKE, T., AWATANI, T., *et al.*

2025

Journal of Health Economics 103: 103046.
https://doi.org/10.1016/j.jhealeco.2025.103046

This study analyzes the effects of the expansion of municipal per capita expenses on health checkup programs, following the introduction of the Specific Health Checkups and Specific Health Guidance (SHC-SHG), on the health outcomes and behaviors of self-employed and unemployed populations, which have been largely overlooked by previous research. To address this, we applied a dosing difference-in-differences (DID) estimation method, exploiting variation in treatment intensity across municipalities. The DID estimation reveals that the SHC-SHG introduction led to a reduction in the proportion of people diagnosed with lifestyle-related diseases in the municipalities that required significant increases in per-capita health checkup program expenses to comply with the new program, with a more pronounced impact on those with multiple diagnoses compared to those with a single diagnosis. A subgroup analysis indicates that health improvements following the SHC-SHG introduction were observed among self-employed workers and homeowners, whereas such improvements were not evident among the unemployed and renters. Moreover, we identify significant behavioral changes among the population in the high-expansion municipalities following the policy introduction. A back-of-the-envelope calculation demonstrates the municipal response to the SHC-SHG introduction is cost-effective.

Are We Making Progress? Testing Whether Interventions to Promote Key Health Behaviors Improved Over the Past 30 Years

SHEERAN, P., PEI, Y. ET ROTHMAN, A. J.

2025

Social Science & Medicine 383: 118484.
https://doi.org/10.1016/j.socscimed.2025.118484

Objective Conceptual and methodological developments could contribute to increasing efficacy of health behavior change interventions over time. We undertook a meta-synthesis to determine whether and to what extent intervention effects have improved during the past 30+ years. Method We retrieved data from 10 meta-analyses of interventions for physical activity, diet, weight loss, alcohol consumption, and smoking cessation (total k = 1,701). Random effects meta-regression analysis was used to test associations between the year of publication of the primary study and the effect size observed for the intervention. Results Year of publication was not related to effect size in physical activity, weight loss, or smoking cessation interventions (ps > .05). Associations for dietary interventions (B = -0.039, p = .001) and for digital and brief interventions to reduce alcohol consumption (B = 6.35 and 2.32, respectively, p < .001) indicated that efficacy was lower in more recent compared to earlier trials. Controlling for potential confounds (e.g., risk of bias, intervention dosage, sample characteristics) did not alter these results. Conclusions Findings from the present meta-synthesis indicate no improvement over time in the efficacy of interventions to promote health behavior change across 5 domains. Rapid changes in products and contexts, the paucity of behavior change trials, and evaluation practices that focus on the efficacy of individual trials rather than cumulative efficacy across trials offer potential explanations of the findings. Innovations are needed to improve intervention efficacy in future trials.

Proactive automatized multiple health risk behavior change intervention: reach and retention among general hospital patients

SPIELMANN, M., KROLO-WICOVSKY, F., TIEDE, A., *et al.*

2025

European Journal of Public Health 35(4): 635-641.
https://doi.org/10.1093/eurpub/ckaf035

Although behavior change interventions are highly recommended in health care, their reach, a core dimension of the public health impact of interventions, is rarely evaluated. This study aimed to investigate whether an individualized, computer-based brief intervention to reduce co-occurring health risk behaviors (HRBs), namely tobacco smoking, at-risk alcohol use, insufficient physical activity, and unhealthy diet, can reach and retain a sufficiently large part of general hospital patients (>75%) and whether patients with high need, that is with more HRBs, low school education or current unemployment may be sufficiently reached and retained. Over 6 weeks in 2022, all 18–64-year-old

patients admitted to 11 wards of five medical departments of a university hospital in Germany were asked to participate in a computer-based HRB screening and in a pre-post intervention study with three further assessments and individualized computer-generated feedback. To investigate associations between intervention reach and retention and patient characteristics, a logistic and a Poisson regression analysis were used. Screening reached 78.9% of all eligible patients (225/285). Of those eligible for the intervention study, 81.8% (175/214) participated in the intervention. Among these, 76.0% (133/175) participated at least once more after hospitalization. Patients' lifestyle and socio-economic characteristics were not significantly associated with reach or retention, Ps ≥ .467. Proactive computer-based multiple-HRB change interventions may reach and retain a sufficiently large part of general hospital patients, including those most in need. When proven efficacious and adequately implemented, this is a promising approach concerning public health impact in the reduction non-communicable diseases. Trial registration: ClinicalTrials.gov NCT05365269, 9 May 2022.

Psychiatrie

Psychiatry

Anxious Dads and Depressed Moms: Child Disability and the Mental Health of Parents

ASUMAN, D., ASGEIRSDOTTIR, T. L. ET JARL, J.
2025
Health Econ 34(7): 1326-1349.
https://doi.org/10.1002/hec.4962

Having a child with a disability undoubtedly affects parents in many ways, including their well-being. However, the specific mental health trajectories of parents, differentiated by the severity of impairments and parental roles, remain under-explored. We investigate the mental-health effects of having a child with a disability. Using individual-level register data from Sweden, we exploit the epidemiological features of Cerebral Palsy (CP) to estimate causal effects. Results show that prescriptions for mental-health disorders increase after the birth of a child with CP. While fathers are more likely to be dispensed anti-anxiety medications, dispensed medications for anti-depressants increase for mothers. Further, the effects are larger for parents of children with severe impairments but do not differ across parental characteristics. Our findings highlight the need for support and assistance for families with children with disabilities.

Reducing mental health emergency department visits through community-based assessment services. A controlled time-series analysis in the city of Lyon, France

BARBALAT, G., DE ROZARIO, R. ET FRANCK, N.
2025
Health Policy 161: 105419.
https://doi.org/10.1016/j.healthpol.2025.105419

ABSTRACT Background The mental health burden on Emergency Departments (EDs) is significant. Community-based mental health services are key to lowering ED visits by addressing mental health needs proactively. Objective To examine the impact of CAdEO, a community-based patient assessment and triage service launched in 2020 in Lyon, France, on psychiatric ED visits among new patients at a local psychiatric hospital. Methods We first used a quasi-experimental interrupted time series design to compare populations exposed (new patients) vs. non-exposed (patients currently under care) to CAdEO from 2015 to 2023. Second, we investigated how the quality of service functioning, measured by delays between referrals and consultations, affected ED visits. Results Exposure to the CadEO service was associated with a 0.5% daily decrease in mental health-related ED visits (Risk ratio (RR): 0.995; 95% Confidence Interval (CI): 0.991, 0.999). Reducing the waiting times for triage from 12 days to 4.7 days over a six-week period was associated with a 26.5% decrease in ED presentations (RR: 0.735; 95% CI=0.548, 0.986). Additionally, males demonstrated a

significant response to the ongoing influence of the service over time, while females were more responsive to cumulative changes in waiting times. Shorter CAdEO waits were linked to lower ED visits for mood and personality disorder patients. Conclusions This study suggests that a community-based patient assessment and triage service may help reduce the overall demand for mental health care in ED. Our findings also highlight the necessity for tailored approaches that consider gender and specific mental health conditions.

Lost in the net? Broadband internet and youth mental health

DONATI, D., DURANTE, R., SOBBRIO, F., *et al.*

2025

Journal of Health Economics 103: 103017.

https://doi.org/10.1016/j.jhealeco.2025.103017

How does the internet affect young people's mental health? We study this question using administrative data on the universe of cases of mental disorders diagnosed in Italian hospitals between 2001 and 2013, which we combine with broadband internet availability at the municipal level. Broadband internet access raises the prevalence of mental disorders among younger cohorts (born between 1985 and 1995) by 0.08 standard deviation units, but it does not impact older individuals (1974 and 1984). The adverse effects are driven by individuals who were exposed early in their lives (before the age of 20). These effects persist when examining instances of self-harm and urgent or compulsory hospitalizations, indicating that the negative outcomes are not merely a result of increased awareness and detection of these conditions. The detrimental impacts span across different pathologies, including depression, anxiety, drug abuse, and personality disorders for both genders, in addition to eating disorders for females.

Mental Health Problems Among Adolescents in Foster Family Care: Prevalence and Trends from 2004 to 2022

FORSMAN, H.

2025

Social Science & Medicine 382: 118345.

https://doi.org/10.1016/j.socscimed.2025.118345

Adolescents in out-of-home care face heightened risks of mental health disorders, yet less is known about the broader range of mental health symptoms and their development over time. This study examines self-reported mental health complaints among adolescents in foster family care compared to their peers in the general population. Using repeated cross-sectional data from the Stockholm School Survey (2004-2022), which includes approximately 114,000 participants, 1% of whom live in foster family care, the study analyzes differences in prevalence and explores temporal trends of these complaints, with a particular focus on gender differences. Multivariable regression analyses revealed significant disparities, particularly among girls, who reported higher risks across emotional, self-perception, psychosomatic, and sleep-related domains. While boys in care also exhibited increased risks, these disparities were less pronounced. General temporal trends indicated increases in complaints for both groups. Although differences in trends between groups were generally not statistically significant, some outcomes showed potential tendencies of narrowing gaps among girls in care, while trends for boys suggested widening gaps for most outcomes. These findings underscore the need for targeted interventions to address persistent mental health challenges faced by this vulnerable group.

Recovery in Mental Health: An International Delphi Study from a Recovery-Oriented Professional Perspective

GUERRERO, E., BARRIOS, M., SAMPIETRO, H. M., *et al.*

2025

Social Science & Medicine 381: 118302.

https://doi.org/10.1016/j.socscimed.2025.118302

Current public policies emphasize the need for recovery-oriented services. However, a lack of consensus on the meaning of recovery poses challenges for implementing recovery-oriented interventions. This study aims to establish an international consensus on the key elements of recovery from the clinician perspective, specifically from recovery-oriented mental health professionals. A three-round Delphi study was conducted to gather expert opinions on the definition of recovery, progress indicators, and factors that facilitate and hinder recovery. Seventy-eight recovery-oriented professionals agreed to participate and completed a sociodemographic questionnaire after providing informed consent. In the first Delphi round, open-ended questions were used to gather initial opinions, which were analyzed and compiled into a list of statements. In

the second and third rounds, participants rated the relevance of each statement using a Likert-type scale. Statements rated as "relevant" or "very relevant" by at least 80% of participants were considered consensus statements. Recovery was defined as the development of a sense of agency, empowerment, autonomy, and self-determination. Key indicators emphasized agency, empowerment, user safety, and informed decision-making. Facilitators included the promotion of self-determination, a holistic approach within services, and the integration of peer support. Social exclusion emerged as the most significant obstacle to recovery. This study provides an international consensus on the key elements of recovery in mental health from the perspective of recovery-oriented professionals, offering insights for implementing interventions, developing recovery-oriented services, and refining measurement instruments.

Young People's Preferences for Web-Based Mental Health Interventions for Managing Anxiety and Depression: A Discrete Choice Experiment

HO, T. Q. A., ENGEL, L., RIDE, J., *et al.*

2025

Applied Health Economics and Health Policy 23(4): 737-749.

https://doi.org/10.1007/s40258-025-00958-9

Anxiety and depression are prevalent in young people. Web-based mental health interventions (W-MHIs) have the potential to reduce anxiety and depression, yet the level of engagement remains low. This study aims to elicit young people's preferences towards W-MHIs and the relative importance of intervention attributes in influencing choice.

Des savoirs expérientiels des personnes concernées aux approches expérientielles : spécificités en santé mentale et psychiatrie

JOUET, E., LAS VERGNAS, O. ET VINÇON-LEITE, A.

2025

L'information psychiatrique 101(6): 383-392.

https://doi.org/10.1684/ipe.2025.2897

Une fois rappelée la place des récits d'expériences en psychiatrie et santé mentale, les auteurs reviennent sur l'actuelle montée en puissance des publications scientifiques qui font référence aux expériences vécues des patients en santé. Ces approches expérientielles des personnes concernées présentent-elles des spécificités en santé mentale et psychiatrie ? À partir de différences cliniques, institutionnelles et de représentations sociales, les auteurs extraient plusieurs spécificités en lien avec les approches expérientielles en santé mentale et en psychiatrie : d'autres façons de penser la clinique, un questionnement sur les altérations de la réflexivité liées aux symptômes psychiatriques, l'effet de la stigmatisation, une asymétrie de pouvoir (encadrée par la loi) et le recours aux soins sous contrainte, à l'isolement ou à la contention.

Adolescent Mental Health: Impact of Introducing Earlier Compulsory School Grades

LINDER, A., GERDTHAM, U. G. ET HECKLEY, G.

2025

Health Economics 34(9): 1731-1746.

https://doi.org/10.1002/hec.4982

ABSTRACT We examine how the earlier introduction of compulsory school grades affects the likelihood of receiving a mental disorder diagnosis among Swedish adolescents. We exploit a school reform that shifted the introduction of grades from grade 8 to grade 6, resulting in first exposure to grading at different ages between cohorts. Our results show that girls exposed to earlier grading are more likely to be diagnosed with internalizing disorders, such as depression and anxiety, by the end of compulsory school. This effect is particularly pronounced among students with low to moderate academic achievement. We also find suggestive evidence that both girls and boys exposed to earlier grading face an increased risk of being diagnosed with alcohol-related disorders. These findings highlight that early exposure to grading may have unintended adverse effects on adolescent mental health. Education systems should acknowledge these potential risks and consider implementing complementary mental health support when revising grading policies.

Deaths of despair: The singularities of French overseas territories

NACHER, M., FERDYNUS, C., DRAME, M., *et al.*

2025

Journal of Epidemiology and Population Health 73(4): 203121.

https://doi.org/10.1016/j.jeph.2025.203121

Background Given the range of alarming social indi-

cators in the French overseas territories, we aimed to study "deaths of despair", pooling deaths from suicide, alcohol, and drug-related deaths and to compare them with mainland France. Methods Standardized mortality rates obtained from death certificates between 2001 and 2022 were used for comparisons. Results Deaths of despair were generally lower than in mainland France, with Reunion Island as an exception. Suicide rates were consistently lower across all territories. However, alcohol-related deaths were notably higher in the overseas territories, particularly among men. The study found that deaths of despair were predominantly driven by suicide in mainland France, while in the overseas territories, they were split nearly equally between suicide and alcohol-related deaths. Drug-related deaths were negligible in the overseas territories. Between 2001 and 2022 deaths of despair declined notably because alcohol-related deaths declined. Conclusions The counter-intuitive finding that, with the exception of Reunion Island, despite all the social difficulties deaths of despair tend to be less frequent than in mainland France suggests that these small territories may have complex resilient features that limit the impact of poverty. While affordable rhum is locally produced populations drink less alcohol when compared to mainland France. However, the risk of dying from it remains a public health problem.

Mental well-being trends and school-based protective factors among adolescents in British Columbia (2015–2022): A population-based study.

OBERLE, E., JI, X. R., MOLYNEUX, T., *et al.*

2025

Social Science & Medicine 380: 118201.

https://doi.org/10.1016/j.socscimed.2025.118201

Background Adolescent mental well-being has declined in the past decade. Much research relies on administrative data and population-based research incorporating youth voices and exploring protective factors for mental well-being is scarce. This study examined trends in adolescent mental well-being from 2015 to 2022 in British Columbia (BC), Canada. We examined sex differences in the trends, the role of protective factors in school, and the relative importance of protective factors for mental well-being. Methods We drew from self-report data from eight years of implementation (2015–2022) of the Middle Years Development Instrument (MDI) with grade 7 students (N = 69,391; 49 % girls) in schools. Positive (satisfaction with life; SWL) and negative (depressive symptoms) mental well-being indicators were examined over time using a repeated cross-sectional design. Analyses were stratified by sex. The presence of 0–3 protective factors (adult support at school, peer belonging, school connectedness) and SES were covariates. Results SWL significantly declined and depressive symptoms significantly increased across the study period and for most adjacent study years. Girls had significantly lower well-being and a steeper decline than boys. For the subset of students who scored high on all protective factors, the decline in well-being was attenuated but not eliminated and the sex gap was reduced. Conclusions The decline in well-being and the protective nature of modifiable protective factors identified in our study highlight the need for population-level mental health strategies that can be implemented in partnership with school districts.

Le savoir expérientiel en santé mentale : un savoir vivant, hybride et politique

ROELANDT, J. L.

2025

L'information psychiatrique 101(6): 379-380.

https://doi.org/10.1684/ipe.2025.2895

Asymmetry and Spillover Effects in the Relationship Between Stock Markets and Mental Health: An Alternative Approach

RUF, R., BERRILL, J. ET CASSELLS, D.

2025

Health Econ 34(8): 1410-1425.

https://doi.org/10.1002/hec.4968

Despite the arguments made by prospect theory, there is a lack of studies investigating asymmetric effects in the relationship between stock markets and mental health. We use the UK based Understanding Society panel dataset between 2010 and 2023 to investigate if stock market fluctuations have an asymmetric impact on mental health, and if there are mental health spillover effects on investors' household members, providing the first paper to investigate this relationship using an asymmetric fixed effects model for panel data. We find that a decreasing stock market index has a stronger impact on mental health than an increasing one, supporting prospect theory. We also suggest that prospect theory does not hold for males in explaining the rela-

tionship between stock market fluctuations and mental health. Finally, we provide novel evidence for a mental health spillover effect of negative 52-week returns on investors' household members.

Mental health and mortality trends in the United States

RUHM, C. J.

2025

Journal of Health Economics 102: 103015.

https://doi.org/10.1016/j.jhealeco.2025.103015

This study investigates whether worsening mental health has played a significant role in the rising mortality rates experienced by some population groups in the early 21st century, a question that has gained prominence with increased attention to so-called "deaths of despair." The main takeaway is that although declining psychological health has likely contributed to adverse mortality trends—especially among prime-age non-Hispanic Whites—its overall impact is limited and not well captured by standard definitions of "deaths of despair." Five key findings support this conclusion. First, mental health deteriorated between 1993 and 2019 for all population groups examined. Second, these declines are associated with higher predicted death rates and help explain worsening mortality trends for prime-age non-Hispanic Whites and, to a lesser extent, non-Hispanic Blacks between 1999 and 2019. Third, while these correlations lend some support to the broader idea of "deaths of despair," the specific causes comprising them appear to be both more expansive and different from those previously emphasized. Fourth, heterogeneity in how worsening mental distress affects mortality—rather than in mental health trends themselves—is more important in explaining Black-White disparities in its overall impact. Finally, in the primary specifications, deteriorating mental health accounts for an estimated 9 % to 29 % of the rise in mortality rates among prime-age Whites in recent years.

Regional variation in mental healthcare utilization and suicide: Evidence from movers in Australia

SAXBY, K., BUCHMUELLER, T., DE NEW, S. C., *et al.*

2025

Journal of Health Economics 102: 103029.

https://doi.org/10.1016/j.jhealeco.2025.103029

Poor mental health is a major global health issue, with many countries documenting high levels of unmet need and regional disparities in mental healthcare utilization. To determine how best to address these disparities, it is important to understand what drives regional variation. Using Census-linked microdata from Australia, we exploit cross-region migration to identify the extent to which patient and place factors drive regional variation in utilization of mental healthcare services and mental health prescriptions (antidepressants, anxiolytics, antipsychotics). We find that place factors account for approximately 72% and 19% of the regional variation in utilization of mental healthcare services and mental health prescriptions, respectively, with the rest reflecting patient-related demand. We also find suggestive evidence that larger place effects predict fewer mental health related ED presentations, self-harm hospitalizations, and suicides. Altogether, our findings suggest there is inadequate and inequitable supply in regions with low utilization, rather than inefficiently high utilization in high utilization regions.

Mental Health of Emerging Adults in New York City in 2023

SUSS, R., CATON, J. A., CLOSE, M., *et al.*

2025

American Journal of Public Health 115(9): 1426-1435.

https://doi.org/10.2105/ajph.2025.308163

Objectives. To investigate the prevalence of serious psychological distress (SPD), mental health treatment, unmet need for mental health treatment, social isolation, and barriers to treatment access among emerging adults, aged 18 to 24 years, and compared with older adults. Methods. We use data from the New York City (NYC) Neighborhood Wellness Survey (2023), a representative survey of adults in NYC (n = 43 606), to calculate weighted prevalence estimates and fit logistic regression models controlling for sociodemographic characteristics. Results. Emerging adults had higher odds of SPD and social isolation than adults aged 35 to 44 years, 45 to 64 years, and 65 years or older, and lower odds of past-year mental health treatment among those with SPD compared with all other age groups. Emerging adults reported different reasons for unmet need for mental health treatment than other age groups. Among emerging adults, individuals who identified as noncisgender, bisexual, or unsure of their sexual orientation, or who experienced financial strain, violence, or discrimination, had poorer mental health outcomes. Conclusions. These findings demon-

strate the need for expanded efforts to increase mental health treatment access focused on those aged 18 to 24 years, as their needs may differ from those of other age groups. (Am J Public Health. Published online ahead of print July 10, 2025:e1–e10. https://doi.org/10.2105/AJPH.2025.308163)

Du savoir expérientiel au partenariat : l'alliance des savoirs

VERKEST, E., BORSELLINO, J. ET CREUPELANDT, C.

2025

L'information psychiatrique Vol. 101(6): 393-399.
https://doi.org/10.1684/ipe.2025.2898

Le savoir expérientiel des personnes vivant avec un trouble psychiatrique, longtemps marginalisé, s'impose aujourd'hui comme un levier essentiel pour transformer les pratiques en santé mentale. À travers une analyse conceptuelle et phénoménologique, cet article explore sa construction et son articulation avec les savoirs des professionnels. En s'appuyant sur les notions de réceptivité et d'accordage, il partage le cheminement par lequel une expérience individuelle peut devenir un savoir pour le collectif, impliquant un travail réflexif, narratif et collaboratif. Enfin, il interroge les conditions d'un partenariat authentique, ancré dans la reconnaissance mutuelle et le dialogue, afin de promouvoir une approche pluraliste des défis complexes de la santé mentale.

The Comparison of Four Models of Community Psychiatry—A Systematic Review and Preliminary Meta-Analysis of the ACT Model

WILK, K., KOWALEWSKA, E., JAKUBOWSKA, M., *et al.*

2025

Clinical Psychology & Psychotherapy 32(1): e70048.
https://doi.org/10.1002/cpp.70048

ABSTRACT Background The aim of this systematic review and preliminary meta-analysis is to summarize the effectiveness of selected models of community psychiatry: community mental health center, flexible assertive community treatment, community mental health team and assertive community treatment. Methods In order to determine the results of therapeutic interventions, comparison of symptom severity, level of functioning, use of institutional care, quality of life/well-being/recovery and satisfaction at baseline and during follow-up was conducted. Thirty-seven quantitative studies were selected, grouped according to the study model and compared in terms of positive, neutral and negative impact on patients according to efficacy factors. Additionally, a preliminary random-effects meta-analysis was performed on 11 studies to investigate the effectiveness of assertive community treatment. Results Review shows the overall positive results of the selected models. The best documented effects were an increase in the level of functioning and a reduction in institutional care. The number of articles collected indicates that community mental health center and assertive community treatment are better researched than community mental health team and flexible assertive community treatment models. Meta-analysis on assertive community treatment studies showed significant pooled effect sizes for domains of functioning, quality of life, hospitalizations and symptom severity. Conclusions The community mental health center and assertive community treatment are most likely to indicate efficiency and safety. The community mental health team and flexible assertive community treatment models should be explored in future studies. Results of the preliminary meta-analysis provide further evidence for the effectiveness of assertive community treatment.

Regional disparities in cognitive life expectancy: The role of birth and current residence in the United States

WONG, J. ET ZANG, E.

2025

Health & Place 94: 103475.
https://doi.org/10.1016/j.healthplace.2025.103475

Regional disparities in cognitive impairment are well-documented, but the combined impact of birth and current residence remains unclear. Prior studies examine geographic patterns, yet none estimate years spent in different cognitive states—key for understanding long-term health and policy implications. Using data from the 1998–2020 Health and Retirement Study (105,491 observations from 19,213 individuals), we employ a Bayesian multistate life table approach to estimate cognitively healthy and impaired life expectancies at age 50 across different combinations of birth and current regions. Our findings show that birth region plays a stronger role in cognitive impairment risk than current residence. At age 50, Southern-born individuals, regardless of where they live later, have fewer years without cognitive impairment (Men: 20.5–21.5; Women: 24.8–25.4) and more years with dementia (Men: 2.3–2.5;

Women: 3.0–3.1) than those born elsewhere. Those both born and living in the South have the shortest cognitively healthy life expectancy. Regional differences based on current residence alone are minimal and only evident when considered alongside birthplace. Beyond the Southern birth disadvantage, we also identify a Western birth disadvantage, particularly in life expectancy with dementia and, for women, a higher percentage of life spent with cognitive impairment but not dementia. This suggests that Western-born individuals, especially women, may experience prolonged cognitive decline even if they avoid full-blown dementia. These findings provide new evidence of the lasting impact of early-life geographic exposures on cognitive impairment risk, underscoring that growing up in certain regions, particularly the South and, in some respects, the West, can shape cognitive health trajectories decades later.

Sociologie de la santé

Sociology of Health

▶ Les usages du genre en santé : de la nécessité de former les enseignant·es

ARENA, F.

2024

Sciences sociales et santé 42(4): 75-82.

https://doi.org/10.1684/sss.2024.0286

▶ How Gender Norms Shape the Health of Women and Men?

BASSOLI, E.

2025

Social Science & Medicine 383: 118479.

https://doi.org/10.1016/j.socscimed.2025.118479

This paper examines the impact of social norms on health disparities, a topic that has received limited attention. By combining two European cross-country datasets, we propose a novel approach to identify the effect of changes in social norms on individual health. We leverage the European Values Study (1999-2017, N=41284) to construct time-varying measures of gender norms in the family and the work domains at the country-year level. These measures are then linked with the Survey of Health Ageing and Retirement in Europe (2004-2017; N=32552) data, which is representative of the older population in Europe. We apply an OLS model, with individuals, country and time-fixed effects to investigate the role of norms on health status. Findings indicate that stronger traditional gender norms in the family likely increase depression among women, whereas more gendered norms at work decrease women's poor health reported. We disentangle some potential mechanisms to test the precise channel by which the type of norm leads to the selected outcomes: financial difficulties, smoking and drinking are among the most critical drivers. These results underscore the significance of gender norms in shaping health and emphasise the need to address them to reduce inequalities and improve societal well-being.

▶ Les savoirs issus de l'expérience dans la production de connaissances sur les politiques publiques

BERTRAND, K., JAUFFRET-ROUSTIDE, M. ET LÉVY, J.

2025

Revue française des affaires sociales 251(2025/1).

Ce premier numéro de la RFAS pour 2025 a pour thème la place des savoirs issus de l'expérience dans la production de connaissances sur les politiques sociales et de santé. Les sujets des sept articles qui composent le dossier thématique témoignent d'un champ en plein développement : non-recours aux prestations sociales, construction d'un observatoire des solidarités, inégalités épistémiques, usage de drogues, recherche collaborative, soins en périnatalité, algues vertes… l'implication des personnes concernées est aujourd'hui largement répandue, aussi bien du point de vue des savoirs que des pratiques. L'objectif de ce dossier est d'en montrer la richesse et la variété, mais aussi les difficultés et les limites, en regard des objectifs affichés de transformation sociale, de réduction des injustices épistémiques et de rapprochement entre sciences et société. Le dossier est complété par un point de vue de

Daniel Cefaï qui propose une généalogie des « savoirs expérientiels », qu'on peut faire remonter, entre autres, au pragmatisme de Dewey et aux self-help groups des années 1960, ainsi que par la synthèse d'un rapport de l'Inspection générale des affaires sociales, évaluant la participation citoyenne dans les politiques de solidarité.

How the country of education affects migrant doctors' acceptance among their patients

GROOT, P. ET ELLEMERS, N.

2025

Social Science & Medicine 383: 118409.

https://doi.org/10.1016/j.socscimed.2025.118409

Background Countries such as the UK are becoming increasingly dependent on foreign-schooled doctors for supplying medical services. This leads to well-known patient—doctor discordance issues, such as lower patient trust in foreign doctors. The role of doctor education in this issue is not well understood, leading us to pose the question: To which extent does the place where a doctor was educated, as opposed to the place where they were born, predict patients' attitudes and behavioural intentions towards that doctor? In addition, we investigate if patients' intentions towards a foreign doctor can be influenced by providing information about three well-known social attributes that may be affected by doctor education, i.e., competence, sociability, and morality. Method Five vignette studies measured the response of majority group members (White, UK or NL-born participants), assuming the role of patients, to migrant doctors who were either educated abroad or in the country of destination (total N = 1181). Results A doctor's birthplace and a doctor's place of education both impacted patients' acceptance of that doctor. Training in the UK, as opposed to a foreign country, was associated with higher levels of competence. However, when presented with negative information about the doctor's competence, sociability, and especially morality, patients' acceptance of that doctor plummeted. Conclusions Providing foreign doctors with training in their country of destination may improve those doctors' acceptance amongst patients. Preventing negative word of mouth about a doctor's moral conduct, more so than about their sociability or competence, should furthermore be an important educational goal.

Doctors as system leaders: medical professionalism and 'making a stand'

JONES, L. ET ARMIT, K.

2025

Social Science & Medicine 381: 118314.

https://doi.org/10.1016/j.socscimed.2025.118314

ABSTRACT Regional collaborative networks are an important focus of healthcare policy around the world. Doctors are increasingly taking up roles as 'system leaders' in these networks. These roles are seen as important for facilitating collaboration between stakeholders to coordinate services and foster innovation. Drawing from a study of 12 senior medical leaders who have taken on the new role of 'Chief Medical Officer' in the Integrated Care Systems in England, we explore how they understand and enact these new system leadership roles. We develop a novel theoretical perspective on medical professionalism as a mode of governance. We contribute original insights on new forms of solidarity and collective action that have important governing mechanisms and effects, such as engaging intrinsic motivation, countering coercive management hierarchies to advance the interests of patients; and 'making a stand' on moral issues. Our analysis rebalances the focus on knowledge in the sociology of the professions. The profession remains an important sociological category because professional ethics continue to furnish meaning and guide action. A professional concern for quality, intrinsic motivation, and professional integrity can promote population health and health equity and uphold the quality and safety of patient care.

No one wants to be a good patient: Intersectionality and agency in the sick role

LU, W.

2025

Social Science & Medicine 382: 118372.

https://doi.org/10.1016/j.socscimed.2025.118372

Making treatment decisions is a responsibility of the sick role granted to ill people. Despite many social roles being granted to ill people, intersecting with the patient role, little is known about what roles and how they intersect in decision-making, particularly what motivates patients to perform patient behaviors under this situation. This study explores the intersectionality and agency in the sick role in cancer treatment decision-making. Thirty-two interviews with cancer

patients reveal the multiple identities, intersected identities, and preferred identities in decision-making on cancer treatment. Surprisingly, the findings show no one claims that they want to be a good patient. The agency to perform a patient role comes from the non-patient preferred identity. This finding informs a narrative approach that regards cancer patients as persons situated in multiple social systems and narrative contexts and thus physicians and all the healthcare stakeholders can facilitate patients' preferred identity to improve their agency in treatment decision-making.

▶ Vers une approche plus globale et inclusive ? Enseigner la dimension sociale du genre et de la sexualité dans les facultés de santé

PLAQUEVENT, B.

2024

Sciences sociales et santé 42(4): 43-73.
https://doi.org/10.1684/sss.2024.0287

Dans la lutte contre les discriminations de santé liées au genre et aux sexualités, le besoin de solutions institutionnelles, et notamment de nouvelles formations des professionnel·les de santé, apparaît aujourd'hui comme un enjeu majeur. S'il n'existe pas de programme obligatoire codifié nationalement sur le genre et les sexualités, une enquête qualitative basée sur des entretiens avec des personnes portant des enseignements sur ces thématiques a permis de cartographier un ensemble d'initiatives créées localement dans les facultés de santé en France. Ces enseignements sont portés par des entrepreneur·ses de causes issu·es de différentes disciplines ou spécialités (SHS, spécialistes de santé sexuelle, psychiatres, etc.) et ils ont donc des objectifs différents selon les cas, avec une grande hétérogénéité dans les thèmes abordés, le degré de biologisation ou de constructivisme dans l'usage de la catégorie de genre, et la visée des enseignements. Cette diversité invite ainsi à se demander ce que le genre fait aux formations médicales.

▶ La santé publique sans la pharmacie ?La stratégie « Tester, tracer, isoler » dans la gestion francilienne de la pandémie de Covid-19

RAYAPOULLÉ, A., BEAUDEVIN, C. ET GAUDILLIÈRE, J. P.

2024

Revue française de sociologie(4): 473-499.
https://doi.org/10.3917/rfs.654.0473

Cet article porte sur les interventions « non pharmaceutiques » dans les réponses françaises à la pandémie de Covid-19 et sur la manière dont elles ont été influencées par la structuration historique de la santé publique du pays. Il étudie le cas de la stratégie « Tester, tracer, isoler » (TTI), en tant que dispositif sociotechnique combinant tests de dépistage, suivi des contacts et isolement à domicile des personnes. Il retrace la manière dont des initiatives locales de « santé communautaire » ont vu le jour à la sortie du premier confinement (mars-mai 2020) et comment leur coordination progressive a conduit à la mise en place d'un dispositif national, créé en dehors des institutions de santé publique, et prenant appui sur l'Assurance maladie. Il analyse ensuite comment la disjonction entre le registre technique et le registre social de ce dispositif a pu précipiter le recours à un deuxième confinement (octobre 2020).

Soins de santé primaire

Primary Health Care

▶ Developing Strategic and Collaborative Community–Academic Partnerships to Improve Community Health, From Moving Upstream to Getting at the Root

ANDERSON, Y., ARTIS, R. ET AUYOUNG, M.

2025

American Journal of Public Health 115(S2): S152-S163.
https://doi.org/10.2105/ajph.2025.308092

Community partners have experienced inequity and lack of transparency in funding practices. Funding for community partners is a critical component of community-engaged research, as it influences community

trust and opportunities. We compared contextual and site-specific factors at 2 centers (in New York City; Los Angeles and Orange Counties, CA) with different community-funding approaches, which influence institutional capacity to partner with and support community-based organizations. We describe community participatory and engaged research activities in two centers in a National Institute on Minority Health and Health Disparities–funded national consortium, describing each center's process for funding community-based organizations. We present lessons learned from ongoing collaborative efforts between community-based organizations, community action boards, and research institutions. We discuss successes and opportunities for growth in our efforts to support community-based organization partners, resources to help sustain their health equity programs, the importance of long-term institutional investment to sustain this type of support, and the potential for institutional-level changes that increase trustworthiness and sustainable outcomes. We advocate for systemic changes in institutional focus and resource investment to better respond to community needs. (Am J Public Health. 2025;115(S2):S152–S163. https://doi.org/10.2105/AJPH.2025.308092)

Accounting for morbidity in capitation payments: A person-based workload formula for primary medical care in England

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

2025

Health Policy 161: 105406.

https://doi.org/10.1016/j.healthpol.2025.105406

Background Accurate needs-based capitation is key to effective and equitable primary care funding. Most capitation schemes use only basic demographic and area characteristics. Objective We developed capitation weights for general practices in England using morbidity indicators recorded in primary and secondary care. Methods We used primary care records from the Clinical Practice Research Datalink (CPRD) linked with Hospital Episode Statistics (HES) for 12,667,755 patients registered with 1397 general practices on 1 April 2018. Using linear regression models, we estimated the effects on cost-weighted clinical appointments of patient age and gender, ethnicity, area-level deprivation, new registration, and morbidity (four sets of indicators covering 20 to 209 conditions). We included practice fixed-effects to adjust for differences in capacity and productivity. We applied the coefficients on patient characteristics as need-weights to data available nationally and we calculated weighted-patients for all 6892 practices in England. Results Most patients (71 %) had at least one appointment per-year. The average annual workload per-patient was £110, with large variations across patients (range £0-£882) and practices (£47-£179). Workload increased with age and with deprivation, but their direct effects halved when including morbidity in the model. Including morbidity widened the range of weighted-patient between practices at the 5th and 95th percentiles (from 0.84–1.14 to 0.79–1.16) and in the least and most deprived deciles (from 0.96–1.04 to 0.95–1.06). Conclusion Needs-based capitation weights accounting for morbidity and adjusting for unexplained variations in practice capacity and productivity increase workload differentiation and direct resources toward practices in more deprived areas.

Does knowing the costs of other physicians affect doctors' referrals?

BARKOWSKI, S.

2025

Journal of Health Economics 102: 103002.

https://doi.org/10.1016/j.jhealeco.2025.103002

Patient referrals from primary care physicians (PCPs) to specialists are common in the American health care industry, but are typically made without any knowledge of relative specialist costs. In this study, I estimate the effect of providing such information to PCPs on referral patterns. Implementing a field experiment with an Independent Practice Association (IPA), I sent a list of average costs for new ophthalmology referrals to randomly chosen primary care medical practices. Using administrative referral data, I find that PCPs increased referral share to less costly ophthalmology practices during the first two months after treatment by 4.6 percentage points for each reduction in costliness rank (e.g., each rank closer to the least expensive). Effects were only found for patients for whom the PCPs had cost reduction incentives, and dissipated over the following four months. For the patients whose referrals were affected, I estimate that the expected cost to the IPA of a referral to ophthalmology fell during the first two months by about $80 (45% of pre-intervention referral cost).

Physicians' incentives, patients' characteristics, and quality of care: a systematic experimental comparison of performance-pay systems

BROSIG-KOCH, J., GROSS, M., HENNIG-SCHMIDT, H., *et al.*

2025

International Journal of Health Economics and Management 25(2): 217-243.
https://doi.org/10.1007/s10754-025-09390-x

How performance pay affects physicians' medical service provision and the quality of care is relevant for researchers and policy-makers alike. This paper systematically studies how performance pay, complementing either fee-for-service or capitation, affects physicians' medical service provision and the quality of care for heterogeneous patients. Using a series of controlled behavioral experiments with physicians and students, we test the incentive effect of performance pay at a within-subject level. We consider a performance pay scheme which grants a discrete bonus if a quality threshold is reached, which varies with the patients' severity of illness. We find that performance pay significantly reduces non-optimal service provision and enhances the quality of care. Effect sizes depend on the patients' severity of illness and whether performance pay is blended with fee-for-service or capitation. Health policy implications, including a cost benefit analysis of introducing performance pay, are discussed.

GPs' willingness to delegate tasks: may financial incentives balance risk aversion?

COMBES, S., PARAPONARIS, A. ET VIDEAU, Y.

2025

Journal de gestion et d'économie de la santé 1(1): 43-64.
https://doi.org/10.54695/jdds.043.1.0043

Industries with more motivated workers are more likely to be productive. Motivations is argued to have an impact on risk-taking behaviours. In the healthcare sector, there are at least three agents interacting in the production of health: an Insurer (NHI), professionals and patients. The NHI may want to modify the behaviour of the professionals towards patients by nudging them into delegating tasks to another professional. In the context of decreasing medical density and unequal distribution of General practitioners (GPs), France, as other many countries, has decided to promote vertical integration between healthcare professionals combined with tasks delegation. Yet, the latter can be particularly costly when fee-for-service (FFS) is the dominant payment scheme and raises question concerning the quality of healthcare services provided to patients. The propensity of GPs to delegate tasks depends on their risk-aversion towards patients' health. In this paper, we study whether financial incentives can alter the negative effect of risk-aversion on GPs' willingness to delegate tasks. To our knowledge, the literature dealing with the determinants of tasks delegation from GPs to paramedics in the usual context of private practices is relatively scarce, especially in the French case. We contribute to this literature by studying the impact of GPs' risk aversion and its interaction with cost sharing due to delegation supported by GPs on their likelihood to delegate tasks to nurses.

Family Physicians' Power and Team-Based Care: Lessons From a 60-year-old Primary Care Clinic

DARCIS, C., PIGEON, M. A. ET MOU, H.

2025

Social Science & Medicine 383: 118248.
https://doi.org/10.1016/j.socscimed.2025.118248

The article focuses on the tension between team-based care approaches that emphasizes interprofessional collaboration and existing power imbalances between family physicians and other healthcare providers. It contributes to the literature on the implementation of team-based care models in primary care clinics by adopting a "governance" perspective, often overlooked in these transitions. While existing research has acknowledged power imbalances between family physicians and other healthcare providers, it has paid less attention to how governance mechanisms may shape these dynamics. Through an in-depth case study of a 60-year-old Canadian primary care co-operative, we address this gap and look at how these power issues play out in a context of collaborative governance and shared decision-making. The methodology is qualitative, relying mainly on data of 42 interviews as well as on observations and document analysis. On the one hand, the research reveals that some governance mechanisms play an important role in a team-based primary care settings, helping attenuate that tension and facilitating collaboration between providers. On the other hand, it shows that, even in a long-standing team-based care model promoting equality between

healthcare professionals and between providers and patients, power imbalances persist. The research illustrates the cultural anchorage of medical domination, highlighting (i) the importance of looking at one organization's informal norms and cultural context when implementing team-based approaches to care, as well as (ii) the critical need for interprofessional education to actively engage with and address the underlying power dynamics that exist within healthcare settings.

Effective Roles of Primary Care Clinics in Lowering Total Cost of Care Among Commercially Insured Populations: A Systematic Review

DEBBARMA, A., DAHAL, R. ET DOWD, B. E.

2025

Medical Care Research and Review 82(4): 287-300.

https://doi.org/10.1177/10775587251323636

Proposals to reduce the cost of health care services and improve the quality of care often involve ambitious expectations for the role of primary care clinics (PCCs). We systematically reviewed the literature to identify interventions PCCs could undertake to reduce avoidable emergency department visits and ambulatory care-sensitive admissions. Database searches resulted in only seven studies that met the inclusion criteria for this review. Very few studies identified interventions that primary care physicians could undertake to reduce total cost of care, possibly because relatively few PCCs are held responsible for total cost of care. Evidence-based interventions to reduce ACS admissions and ED use included case-management models, clinical decision-support tools, & care plans integrated into patients' electronic medical records. The interventions highlighted a heightened role for PCCs in care coordination and access to care that could lead to patients actively engaging in care management and consulting PCCs before seeking urgent care.

Implications of multiprofessional collaboration in primary care – benefits for all? A quantitative study of effects on resource utilization of a team-based primary care practice in Sweden

GLENNGARD, A. H. ET HARALDSSON, M.

2025

Health Policy 159: 105382.

https://doi.org/10.1016/j.healthpol.2025.105382

We investigate differences in resource utilization between a multiprofessional team-based primary care practice and standard care for elderly patients with complex needs, from the perspective of different actors involved in healthcare delivery. The study is based on a mobile care team reform in a Swedish region, that spans across both organisational boundaries and different legislation. Our findings suggest that a shift towards a more proactive approach to outpatient care initially may lead to higher resource utilization and prevent hospital care and contribute to a more effective use of resources in the long run. The pattern observed is consistent the intentions behind the implementation of interventions aimed at shifting care closer to patients. Therefore, when implementing such interventions, it is important for decision-makers to be prepared to accept increased resource use initially in order to potentially benefit in the future. Our study highlights the challenges of measuring and comparing resource utilization across different actors. When implementing healthcare reforms that span across organisational borders, it is crucial to systematically collect and compile comparable data. Reliable information on the costs and patient outcomes associated with new ways of providing care, is important from both a management and a policy perspective.

Exploring differences in performance management across public and private providers in primary care: Evidence from Finland and Sweden

GLENNGARD, A. H. ET MALMI, T.

2025

Health Policy 159: 105383.

https://doi.org/10.1016/j.healthpol.2025.105383

We employ a qualitative approach to explore whether and how the use of performance measurement systems differs between public and private providers in Swedish and Finnish primary care, from the perspective of primary care centre managers. The two settings are similar in terms of decentralised healthcare systems but differ in terms of organisation of primary care and governance principles for public and private providers. Our findings highlight the importance of considering contextual factors when interpreting results on differences between public and private providers. We observe a) increased goal clarity and an increased use of management controls when payment is separated from provision, b) a similar use of control practices between public and private providers when they

operate under the same governance principles, and c) differences in control practices when the "rules of the game" differ. We identify two actions that can facilitate performance management at the provider level. One is for purchasers or owners to clearly communicate the scope of services for which providers are responsible for to improve their goal clarity. The other is for an actor at the national level to facilitate access to reliable data to enhance appropriate performance management and the sharing of experiences among providers.

Equal Access to Primary Care – A Reference for Spatial Allocation in Germany

HAERING, A., KAEDING, M. ET WERBECK, A.

2025

Health Policy 158: 105364.

https://doi.org/10.1016/j.healthpol.2025.105364

Background Equal access to primary care is essential for a reliable health- care system, as it influences health outcomes, reduces follow-up visits, and lowers overall healthcare costs. However, inequalities in access, often driven by the uneven geographical distribution of primary care physicians, remain an issue in Germany. Objective We investigate the regional distribution of primary care physicians in Germany and analyze to what extent regional disparities can be explained by observable infrastructural and environmental characteristics. Methods To investigate our research question, we apply a greedy capacitated algorithm on very fine spatial data. We compare our reference allocation of primary care physicians to the status quo using OLS regressions and a Oaxaca-Blinder decomposition. Results Our findings indicate a shortage of primary care physicians in Germany of approximately 6%, with rural areas being particularly affected. While some disparities can be partially explained by factors such as purchasing power and the number of schools, significant portions of the variation remain unexplained. Conclusion We offer ideas on how to improve primary care location planning and reduce regional disparities based on an algorithmic reference allocation and the analyzes of infrastructural and environmental factors' impact on regional disparities. While being limited by the exclusion of other determinants of health, we provide a foundation for developing more targeted policies.

The Role of Private Equity in the German Outpatient Sector

JOCHIMSEN, B. ET GIBIS, B.

2025

Health Policy 161: 105389.

https://doi.org/10.1016/j.healthpol.2025.105389

Outpatient medical care in Germany has traditionally been delivered by self-employed physicians, primarily in solo or small group practices. A 2004 reform allowed corporate private investors, to finance outpatient care for the first time. Since then, the establishment of so-called medical care centres (MCCs) has become a staple of public healthcare. From the outset, concerns have been raised that economic interests could conflict with the values of a public health system. However, there is a notable lack of empirical evidence to support this potential conflict. This study seeks to narrow the empirical gap using three methodological approaches: a scoping review, identification of relevant data sources, and a brief case study. Our findings indicate that, to date, there is no empirical evidence suggesting a decline in the quality or scope of healthcare services when MCCs are financed by private equity investors. Nonetheless, the potential emergence of oligopolistic structures and a lack of transparency in provider ownership and structure call for careful regulatory oversight. Policy recommendations include strengthening the data infrastructure with respect to medical outcomes, costs, and provider characteristics (e.g. ownership or affiliations), and safeguarding medical decision-making from profit-driven influence by owners. As rising private investment, including private-equity, in outpatient care is observed across nearly all healthcare systems, an internationally comparative approach is essential.

The role of providers' intrinsic motivation for quality of care and responses to a non-financial incentive

OXHOLM, A. S., ANDERSEN, M. K., WALDORFF, F. B., *et al.*

2025

Social Science & Medicine 382: 118378.

https://doi.org/10.1016/j.socscimed.2025.118378

Providers' intrinsic motivation is deemed important for quality of care and responses to incentives. Building on self-determination theory, we test the hypotheses that more intrinsically motivated providers perform better and respond less to an external incentive. We exploit

the introduction of a cluster randomised accreditation scheme in Danish general practice, where practices were randomised to accreditation in different years (2016-2018) at municipality level. Combining data from administrative registers and a nationwide survey, we measure practices' quality of care and their general practitioners' intrinsic motivation. Using weighted mixed linear models with municipality random effects, we compare quality of care of accredited practices and practices in transition with non-accredited practices, while taking intrinsic motivation into account. We find a positive relationship between intrinsic motivation and performance on some quality measures. We also find that intrinsic motivation moderates practices' response to accreditation. While the least intrinsically motivated practices respond to accreditation by increasing their performances, the most intrinsically motivated practices do not respond to the incentive. These findings support the self-determination theory suggesting that intrinsically motivated providers are more autonomous and therefore less susceptible to external interventions. Policymakers should therefore consider taking providers' intrinsic motivation into account when designing incentives.

Strengthening Primary Health Care: The New Contribution of Midwives to Gynecological Care in France.

ROQUEBERT, Q., PANJO, H. ET FRANC, C.

2025

Health Policy 161: 105397.

https://doi.org/10.1016/j.healthpol.2025.105397

Many OECD countries are implementing reforms that redefine the roles of healthcare professionals to improve access to care and enhance the efficiency of the healthcare sector. In 2009, in a context of a shortage of gynecological primary care, France introduced a reform that expanded midwives' scope of practice to include gynecological care for non-pregnant women, alongside their traditional roles in pregnancy and childbirth. This paper explores the effect of this reform on women's healthcare utilization and examines how this effect varies according to women's characteristics. Using administrative data on healthcare utilization among French women, we analyze changes in the probability of consulting a midwife between 2007 and 2017 among non-pregnant women aged 15 to 55. Our results show an increase in midwives' use following the reform, particularly among recently pregnant women and those living in areas with poor access to healthcare services. Overall, the effect of the reform extending the primary care roles of health professionals on the use of care depends strongly on the provision of information about these new skills to the general public. Furthermore, we show that this reform is likely to strengthen the gynecological primary care supply in disadvantaged areas.

Point de vue sur la Prise de Décision Partagée : une enquête territoriale auprès des professionnels de santé

ROBIN, S., CARTRON, E., MORET, L., *et al.*

2025

Annales Pharmaceutiques Françaises 83(4): 761-768.

https://doi.org/10.1016/j.pharma.2025.02.004

Résumé Contexte et objectifs: La Prise de Décision Partagée (PDP) est une démarche intuitive chez les professionnels de santé mais encore peu formalisée ou enseignée en pratique en France. En 2022, nous avions réalisé une étude qualitative sur la perception du concept de PDP auprès d'un panel pluri-professionnel. Ont émergé plusieurs thématiques, notamment autour de la connaissance du concept, de sa mise en place en pratique et du besoin de formation. L'objectif de cette étude est de confronter les résultats obtenus dans notre étude qualitative à un plus grand nombre de professionnels à l'aide d'un questionnaire. Méthodes: Diffusion territoriale d'un questionnaire à destination des professionnels et étudiants médicaux, paramédicaux et non-médicaux durant le second semestre 2022. Les variables quantitatives sont décrites en effectifs proportions. Les résultats issus des questions ouvertes ont été analysés par un codage axial des verbatims, regroupés en catégories, thèmes et sous-thèmes. Résultats: Un total de 381 réponses a été collecté auprès de 10 professions (dont 41 % médecins, 17 % pharmaciens, 15 % infirmiers, 8 % sage-femmes et 8 % masseurs kinésithérapeutes). Moins d'un tiers des répondants (28 %) déclarent être formés à l'éducation thérapeutique des patients (ETP). Seuls 6 % des répondants déclarent connaitre parfaitement la PDP alors que 53 % ne connaissent pas le concept. Lorsqu'il leur est demandé de définir la PDP, la réponse est adaptée dans 33 % des cas. La majorité (81 %) des répondants souhaiterait avoir une formation spécifique et 84 % pensent qu'il y a un lien entre PDP et ETP. Concernant les limites du concept, 75 % des répondants évoquent un contexte d'urgence dans la prise de décision, 72 % le manque de temps, 49 % les difficultés d'organisation et la méconnaissance du concept et 42 % la méconnais-

sance des outils d'aide disponibles. Parmi les leviers évoqués par les répondants, on retrouve : renforcement de l'alliance thérapeutique (67 %), demande des patients (60 %), aide à l'inter-professionnalité (56 %), motivation des équipes (53 %) et amélioration du parcours patient (44 %). A partir des 130 réponses libres sur les besoins pour la mise en œuvre de la PDP, 6 thématiques ont émergé : besoins orientés vers les professionnels et vers les patients, déploiement de ressources matérielles, adaptation à certaines spécialités, responsabilité institutionnelle et difficulté à trouver des solutions d'aval. Conclusion: La construction de ce questionnaire à partir de l'étude qualitative permet de continuer la réflexion. L'implémentation du concept dans la pratique semble être encore minoritaire. Les limites et leviers ressortis au travers de l'analyse qualitative sont confirmés. Le développement d'une formation spécifique et adaptée semble nécessaire et souhaité à la mise en œuvre du processus de PDP, même chez les personnes formées à l'ETP. Summary

Do Rurality-Based Financial Incentives Improve Equity of Primary Healthcare Access? Evidence From Australia

SAXBY, K. ET ZHANG, Y.

2025

Health Economics 34(9): 1679-1690.

https://doi.org/10.1002/hec.70000

ABSTRACT In Australia, as in many other countries, people living in rural and remote areas experience poorer health outcomes and use less primary healthcare compared to urban populations. Aiming to reduce these inequities, in 2022 the Australian government increased rural-based financial incentives for General Practitioners (GPs) to "bulk bill" (i.e., provide care with zero patient out-of-pocket costs) children and concession card holders (low-income patients and older adults) living in rural and remote, but not urban areas. Using whole-of-population administrative data and exploiting variation in the eligibility of geographic areas to receive these incentives, we find that, compared to people living in urban areas, the reform led to a 2.7% (95% CI 2.2; 3.2) increase in the number of GP visits, a 9.0% (95% CI 8.4; 9.5) increase in the number of bulk billed GP visits, and a 13.0% (95% CI 12.4; 13.7) reduction in the out-of-pocket cost per GP visit among people living in rural areas. Effects were more pronounced for people with higher initial out-of-pocket costs—adults rather than children, people without concession cards, and people living in areas with less socioeconomic disadvantage. Altogether, while the reform has gone some way to reduce out-of-pocket costs for rural patients, benefits are unequal and inequities in access remain.

Impact of territorial case management on hospital admissions for complex chronic patients in Catalonia (Spain)

VAQUERO CRUZADO, J. A., JIMÉNEZ, N. G., CIÉRCOLES, L. C., *et al.*

2025

Health Policy 159: 105384.

https://doi.org/10.1016/j.healthpol.2025.105384

Background Chronic diseases are the most frequent health problem in the population. The development of case management, as an advanced care practice, is a basic strategy in the care of complex chronicity. The Catalan Health Plan establishes general guidelines for chronic care, linked to the role of the nurse case management. Objective The objective is to analyse the impact on the health system of shared monitoring, by the chronicity care team and its primary care reference team, in patients identified as complex chronic diseases (CCP) or with advanced disease (MACA), in regarding hospital admissions. Methods Retrospective quasi-experimental intervention study, with pre-post analysis, comparing each patient one year before and one year after being incorporated into the case management portfolio of a team made up of 14 nurses, 2 family medicine specialists and one social worker, with attention 365 days a year, 24 h a day. Results Regarding the decrease in hospital admissions, an average decrease (2013–2021) of 56 % was observed for MACA and 53 % in CCP. Statistical analysis based on a Poisson regression model with offset demonstrates that the intervention program had a significant effect on reducing hospital admissions, from a team formed from primary care itself. Conclusions The organization and structure of a chronic care team such as the one described, in an integrated manner with other levels of care, allows for a significant reduction in hospital admissions.

Travail et santé

Occupational Health

Exploring the link between perceived job insecurity and sickness absence for common mental disorders

BLOMQVIST, S., HÖGNÄS, R. S., FARRANTS, K., *et al.*

2025
European Journal of Public Health 35(4): 650-656.
https://doi.org/10.1093/eurpub/ckaf023

Perceived job insecurity is associated with poor mental health, but whether it affects sickness absence is not well understood. The present study examines the association between perceived job insecurity and sickness absence due to common mental disorders and whether changes in perceived job insecurity affects the risk of sickness absence due to common mental disorders. Data are from the Swedish Longitudinal Occupational Survey of Health and include those who participated at least once between 2010 and 2020 (n = 24 049). Two different types of analyses were conducted: (1) logistic regression with adjustments for baseline covariates and (2) pooled logistic regression with inverse probability weights, across 5 emulated target trials assessing onsets and/or offsets of job insecurity versus stable security or stable insecurity, on the risk of sickness absence for common mental disorders. Perceived job insecurity was associated with increased odds of sickness absence for common mental disorders over a 2-year period (odds ratio = 1.38, 95% confidence intervals (CI) 1.13-1.68). We found no statistically significant associations for an onset of job insecurity versus being stably secure (risk ratio (RR) 1.484, 95% CI 0.913-2.055) nor for offset versus stable insecurity (RR 0.855, 95% CI 0.308-1.402). The findings from our emulated target trials were, however, uncertain. Findings suggest that perceived job insecurity increases the risk of sickness absence for common mental disorders. The study implies that efforts to increase employee's sense of security may help reduce rates of sickness absence for common mental disorders if job insecurity is reduced long-term.

Mental health as a determinant of work: a scoping review on the impact of mental health on precarious employment

DE OLIVEIRA, C., JAMIESON, M. ET BONATO, S.

2025
Health Policy 161: 105395.
https://doi.org/10.1016/j.healthpol.2025.105395

Background While many studies have examined the impact of precarious employment on mental health, the reverse relationship has received less attention. Objectives The objectives of this scoping review were to ascertain the existing literature examining the impact of mental health on precarious employment and to describe, synthesise, and critically appraise it. Methods Business Source Premier, EconLit, Embase, MEDLINE, PsycINFO, and Web of Science were searched from 1 January 1980 to 30 August 2024. Additionally, searches were undertaken in Google and specific websites; references of key papers were also examined. Relevant data were extracted from studies, and their quality was assessed, namely whether they accounted for endogeneity. Evidence was synthesised by mental disorder/illness/problem using a narrative synthesis approach. Results After duplicates were removed, the search yielded 10,048 unique records; ultimately, 19 relevant papers, corresponding to 20 unique studies, were deemed relevant. Few specifically focused on mental health as a determinant of precarious employment and/or recognised the potential presence of endogeneity. Studies found mixed evidence on the relationship between mental health and precarious employment. While the evidence suggests that psychological distress and mental health complaints likely increase the probability of precarious employment, anxiety and emotional exhaustion likely do not. The evidence on depressive disorders is mixed/inconclusive. Conclusion Some of the existing literature suggests that people with poor mental health may be at a higher risk of precarious employment; however, in some instances, the evidence was either mixed/inconclusive or absent. More high-quality studies are needed to inform clear policy recommendations.

Ne pas se sentir capable de faire le même travail 2 ans plus tard, du fait de son état de santé, diffère selon les conditions de travail

GUILBERT, M., ROLLIN, L., VOLKOFF, S., *et al.*

2025

Archives des Maladies Professionnelles et de l'Environnement 86(4): 102885.
https://doi.org/10.1016/j.admp.2025.102885

Résumé Contexte Une des façons de repérer précocement les salariés à risque de décrochage professionnel à moyen terme est de leur demander s'ils pensent que leur état de santé leur permettrait d'effectuer, dans 2 ans, le même travail qu'actuellement – notion nommée par la suite « capabilité perçue de travail ». L'objectif principal de cette étude était d'identifier les conditions de travail associées avec la capabilité perçue de travail, l'objectif secondaire, de valider les liens entre la santé perçue des salariés et la capabilité perçue de travail. Méthodes Les données pondérées de l'échantillon national 2022–2023 de l'observatoire Evrest ont été mobilisées pour ce travail. Seuls les salariés de 45 ans et plus ont été inclus dans l'étude. Des modèles de régression logistique uni-, puis multivariés ont été utilisés pour étudier les liens entre capabilité perçue de travail et conditions de travail, d'une part, santé perçue, d'autre part. Résultats À la question sur la capabilité perçue de travail 2 ans plus tard, parmi les 4173 salariés de 45 ans et plus, 4,6 % avaient répondu « non, sans doute pas », 19,8 % « ce n'est pas sûr » et 75,6 % « oui, c'est à peu près certain ». Les contraintes physiques, l'intensité du travail, le manque de ressources psychosociales et la pression psychologique étaient significativement liées à la capabilité perçue de travail. La présence de plaintes ou symptômes qui gênent dans le travail concernant les problèmes ostéoarticulaires au niveau des membres inférieurs, des vertèbres dorsolombaires, l'anxiété, la fatigue et la lassitude, les troubles auditifs et les troubles digestifs, étaient significativement associées à un doute sur la capabilité perçue de travail 2 ans plus tard. Conclusion Le décrochage professionnel pourrait être limité en poursuivant l'amélioration de certaines conditions de travail particulièrement sélectives chez les salariés ayant des problèmes de santé.

All-cause and cause-specific mortality differences between migrant workers and local workers: a population-based cohort study in Denmark

LAU, K., MKOMA, G. F., KRESHPAJ, B., *et al.*

2025

European Journal of Public Health 35(4): 672-679.
https://doi.org/10.1093/eurpub/ckaf058

Migrants are prone to poor working conditions in high-risk industries, yet little is known about their mortality risk compared to local-born workers. This study compares all-cause and cause-specific mortality between foreign-born and local-born workers, and identifies at-risk foreign-born workers. A nationwide register-based cohort study was performed using data on migrant workers obtaining residence permits in Denmark during 2015–22. Comparison group comprised Danish-born workers matched by age and sex. Survival analysis using extended Cox model was used to estimate all-cause and cause-specific mortality. Subgroup analysis was conducted by region of birth, economic sector, and occupation. Male migrant workers from Central Europe, Eastern Europe, and Central Asia had higher risk of all-cause mortality than Danish-born workers (HR = 1.30 [95% CI: 1.09–1.54]), attributed to accident deaths (HR = 1.64 [1.06–2.53]), whereas migrants from other regions had lower risk. Migrant workers from these regions were more likely to work in high-risk economic sectors and occupations, such as agriculture and construction. When stratified by economic sector and by occupation, among the elementary occupations, migrant workers from these regions still had a higher risk of all-cause mortality (HR = 1.70 [1.10–2.64]) and accident mortality (HR = 1.51 [1.22–1.85]) than Danish-born workers. Migrant workers from Central Europe, Eastern Europe, and Central Asia are more likely to die from accidents than Danish-born workers. This increased risk was partially explained by their higher representation in at-risk sectors and occupations. There is a need to better understand the structural determinants of health faced by these migrants, particularly in elementary occupations, to prevent avoidable deaths.

Access to Paid Sick Leave and COVID-19 Vaccination Status Among Employed Adults Aged 18–64 Years in the United States, 2021–2022

LUNDSTROM, E. W., ASFAW, A. ET TSAI, R.

2025

American Journal of Public Health 115(8): 1308-1311.
https://doi.org/10.2105/ajph.2025.308095

Objectives. To measure the associations between access to paid sick leave (PSL) and COVID-19 vaccination status in the United States, both overall and stratified by occupation and industry of employment. Methods. We extracted data on employed adults aged 18 to 64 years from the 2021 and 2022 US Medical Expenditure Panel Survey. We assessed associations between PSL and COVID-19 vaccination status using logistic regression. We used marginal effects analyses to estimate associations within occupation and industry groups. Results. Our analytic sample (n = 15 089) represented more than 114 million employed US adults. Access to PSL was significantly associated with receipt of a COVID-19 vaccination (adjusted odds ratio = 1.33; 95% confidence interval = 1.14, 1.55). Marginal effects analyses indicated that this association was significant within most occupation and industry groups. Conclusions. These findings suggest PSL is associated with higher COVID-19 vaccination rates among US workers. PSL remains an important tool for improving preventive health care access and reducing rates of infectious disease in the United States. (Am J Public Health. Published online ahead of print May 22, 2025:e1–e4. https://doi.org/10.2105/AJPH.2025.308095)

The effects of state paid sick leave mandates on parental childcare time

MACLEAN, J. C. ET PABILONIA, S. W.
2025

Journal of Health Economics 103: 103033.
https://doi.org/10.1016/j.jhealeco.2025.103033

The U.S. lacks a federal paid sick leave policy. To date, 17 states and the District of Columbia have adopted or announced paid sick leave mandates that require employers to provide up to seven days of paid leave per year that can be used for family responsibilities and healthcare. Using time diaries from the 2004–2023 American Time Use Survey and difference-in-differences methods, we estimate the effects of these state paid sick leave mandates on parents' time spent providing childcare. We find that post-mandate, parental time spent providing primary childcare time increases by 5.8%, with effects being driven by women with younger children. Parents also increase their total time with children by 3.4%, and fathers living with school-aged children only increase their time supervising children while participating in leisure activities by 12%. Overall, our findings suggest that paid sick leave mandates allow working parents to better balance work and childcare responsibilities.

Sickness absence trajectories and retirement pathways among industrial workers

NEUPANE, S., PRAKASH, K. C., NOSRATY, L., *et al.*
2025

European Journal of Public Health 35(4): 665-671.
https://doi.org/10.1093/eurpub/ckaf104

We studied the trajectories of sickness absences among industrial workers over 6 years and examined whether the membership of trajectories was associated with subsequent retirement type for 11 years. We used data from one of the largest Finnish food industry companies that responded to a questionnaire survey in 2003. Sickness absence days per year from 2003 to 2008 were obtained from the company's registers and linked to the register of Finnish Centre for Pension data (statutory and non-statutory) until the end of 2019. We analysed data from 633 individuals who had information on sickness absence and the type of retirement. Latent class growth modelling was used to identify trajectories of sickness absence days per year, and Cox-regression models were used to examine the association of trajectories with retirement type. The models were adjusted for baseline sociodemographic, work-related physical, and psychosocial factors. We identified three distinct trajectories of sickness absence during the 6-year period. Most respondents (51.2%) had low-fluctuating, one-third (33.9%) had moderate-stable, and 14.9% had a high-stable sickness absence trajectory throughout. The high-stable trajectory was associated with a higher risk of non-statutory retirement (hazard ratio 2.67, 95% confidence interval 1.69–4.23) when adjusted for sociodemographic, perceived health, and work-related variables. We found significant heterogeneity in the number of sick absence days per year among the private sector employees over a period of 6 years. An increase in the risk of non-statutory retirement among those with high-stable sickness absences signifies the importance of early intervention to support individuals experiencing recurring sickness absence whilst employed.

Person-related work and the risk of cardiovascular disease: a Swedish register-based cohort study.

PAN, K. Y., ALMROTH, M., NEVRIANA, A., *et al.*

2025

European Journal of Public Health 35(4): 657-664.
https://doi.org/10.1093/eurpub/ckaf080

Person-related work requires interaction with individuals not employed at the workplace, such as clients and patients, and can result in emotional labour, emotional demands, and confrontation. These stressors may increase workers' risk of cardiovascular disease (CVD), including coronary heart disease (CHD) and stroke, whereas colleagues' support may help buffer their impact. We aimed to examine the association between person-related work and the risk of CVD, and effect modification of social support at work. The study included around two million CVD-free workers aged 40–60 years in Sweden in 2006. Three dimensions of person-related work, including general contact with people, emotional demands, and confrontation, and job control and social support were respectively assessed using job exposure matrices. CVDs in 2007–20 were recorded in patient and death registers. Multivariable Cox regression models were used. A total of 114 404 individuals developed CVD (65 857 CHD and 48 547 stroke). High exposures to the three dimensions were associated with 4%–12% increased risks of CVD (7%–20% for CHD and 2%–7% for stroke) in women and 2%–8% (2%–7% for CHD and 3%–10% for stroke) in men. Adjusting for job control attenuated the associations for general contact with people in women. The increased risks related to emotional demands and confrontation in women and general contact with people and confrontation in men were not present in those more likely to receive high social support. In conclusion, person-related work is associated with an increased risk of CVD, and social support at work seems to modify the magnitude of this association.

Vieillissement

Ageing

Enjeux de santé publique du vieillissement de la population : les nonagénaires

ANKRI, J.

2025

Bulletin de l'Académie Nationale de Médecine 209(7): 991-1001.
https://doi.org/10.1016/j.banm.2025.02.015

Résumé Les nonagénaires vont voir un fort accroissement de leur nombre sans que notre société se soit préparée à cette progression. La littérature sur le sujet est éparse et les données souvent insuffisantes. Avec la compression de la morbidité aux âges les plus avancés de la vie nous allons être confrontés à de nombreux problèmes de prise en charge, à des problèmes socio-économiques et éthiques. Il est essentiel que la recherche se développe depuis la génétique jusqu'aux aux sciences humaines et sociales en passant par la clinique et l'épidémiologie. Cette population est laissée pour compte dans la recherche thérapeutique et l'évaluation des médicaments. Tous ces travaux sont nécessaires pour répondre le mieux possible à ces défis de santé publique que nous lancent les nonagénaires. Toutes nos actions ne peuvent pas s'exclure de la dimension environnementale (de l'habitat, de la cité mais aussi de la pollution et du climat) ni de la réflexion éthique d'autant que cette population aborde sa dernière décennie.

Understanding the measurement of autonomy: what, who, how, and why?

BAUMSTARCK, K., DUCA, S. D., EL OUAZZANI, H., *et al.*

2025

Journal of Epidemiology and Population Health 73(4): 203138.
https://doi.org/10.1016/j.jeph.2025.203138

The Impact of Introducing Managed Care Intermediaries for Long-Term Services and Supports

BHAUMIK, D., WALLACE, J., GRABOWSKI, D. C., *et al.*

2025

Health Services Research 60(4): e14462.
https://doi.org/10.1111/1475-6773.14462

ABSTRACT Objective To study the impact of managed long-term services and supports (MLTSS) on the use of long-term care, as well as acute care. Study Setting and Design We use a staggered difference-in-differences (DiDs) regression design, exploiting the variation in timing of the rollout of MLTSS programs across states between 2004 and 2018. We compared individuals in states that implemented MLTSS with individuals in states that did not implement MLTSS. Our outcomes included formal home care use, nursing home status, informal care use, hospitalizations, overnight nursing home visits, and falls. Data Source and Analytic Sample This study uses secondary data from the Health and Retirement Study data, linked with state identifiers. The sample includes adults aged 65 and older who report at least one functional limitation. Principal Findings The shift to MLTSS leads to a 2.5 percentage point (pp) increase (95% CI: 0.8 pp, 4.3 pp) in home care users, a 3-percentage point decrease (95% CI: –5.38 pp, –0.25 pp) in informal care users, and no statistically significant change in nursing home occupancy or health outcomes. We also find suggestive evidence of reductions in the number of home care individuals living in MLTSS states receive, with a 7.02-h (95% CI: –12.96, –1.07), or nearly 27% decrease, in monthly formal care received by this population. Conclusion These findings suggest that MLTSS increased the share of home and community-based services (HCBS) users but restricted the amount of HCBS used per beneficiary, with ambiguity around whether this occurred at the expense of beneficiaries.

▶ Explaining the long-term care insurance puzzle: The role of preferences for correlation and for quality of life over wealth.

CRAINICH, D., GOLDZAHL, L., JUSOT, F., *et al.*

2025

Journal of Health Economics 103: 103030.
https://doi.org/10.1016/j.jhealeco.2025.103030

The paper investigates the role of two demand-side determinants of long-term care insurance: correlation preference and relative preference for quality of life over wealth. We model the effect of those preferences on the joint decision to buy long-term care and long-term care insurance contract. We test the model using data from a laboratory experiment in France. While the experimental results offer only partial support for the theoretical predictions—specifically, correlation aversion does not account for over-insurance, our analysis provides evidence that correlation seeking and the relative preference for quality of life over wealth explain the limited uptake of long-term care insurance.

▶ Nursing home payroll subsidies and the trade-off between staffing and access to care for Medicaid enrollees

HEGLAND, T. A.

2025

Journal of Health Economics 103: 103042.
https://doi.org/10.1016/j.jhealeco.2025.103042

Payroll subsidies are a promising tool for increasing nursing home staffing levels. However, promoting increased staffing may come at the expense of access to care for Medicaid enrollees if it enables nursing homes to attract more lucrative, non-Medicaid residents. In this study, I examine a set of payroll subsidies offered by state Medicaid programs between 1998 and 2010, using nursing home-level variation in subsidy generosity to identify subsidy effects. I find that each additional (2010) dollar of subsidies offered per resident-day increased staffing by just over 10 min per resident-day, but decreased the Medicaid share of new nursing home admissions by about 1.8 percentage points. These figures translate into overall average treatment effects equivalent to an increase in staffing by approximately 7.4% of pre-subsidy average staffing, and a decrease in the Medicaid-share of admissions by 11.5% relative to the pre-subsidy baseline. The subsidies also increased nursing home resident turnover and decreased the average care needs of newly admitted residents. Overall, these results highlight that while nursing home payroll subsidies are effective tools for encouraging increased staffing levels, the subsidies also can lead to changes in nursing home admissions and the characteristics of admitted residents.

▶ Functional limitations in 2004–22 among Europeans aged 55–69 years: time trends according to labor market group and impacts of the COVID-19 pandemic

LISKO, I. K., KURKELA, O., URTAMO, A., *et al.*

2025

European Journal of Public Health 35(4): 693-700.
https://doi.org/10.1093/eurpub/ckaf054

In terms of work ability, impacts of the Coronavirus disease 2019 (COVID-19) pandemic on functional ability warrant investigation. The aim is to explore trends in functional limitations in 2004–22 focusing on the impacts of the pandemic among older working-aged Europeans in different labor market groups and at different levels of COVID-19 stringency policies. Data come from the Survey of Health, Ageing and Retirement in Europe (SHARE) collected in 2004–22. Individuals aged 55–69 years from 27 countries were included (N = 245 060). Outcome was functional limitations (Global Activity Limitation Index). Generalized estimating equations were used to analyze time trends and COVID-19 impacts within labor market groups and at different levels of COVID-19 stringency policies. In 2004–22, the likelihood of functional limitations increased slightly among men but remained the same among women. Functional limitations were more likely in countries with low and moderate as compared to high COVID-19 stringency (which represents mostly Southern Europe) in both women and men. During the ~1st year of the pandemic, likelihood of functional limitations decreased especially in countries with moderate COVID-19 stringency. Decreases were observed in all labor market groups. During the ~2nd year of the pandemic, the likelihood of functional limitations increased in time but not statistically significantly in most groups. Policymakers should be aware of trends in functional limitations and the impacts of policy decisions while pursuing to prolong work careers. Further investigation is required to verify our findings and to explore underlying reasons behind the decreases in functional limitations after the pandemic.

The use of Social Return on Investment approaches to evaluate integrated long-term care in high-income countries: a scoping review

MARQUES, S. R., RODRIGUES, R., ZERTH, J., *et al.* (2025

Health Policy 161: 105414.

https://doi.org/10.1016/j.healthpol.2025.105414

Background : The increasing number of older adults with complex care needs underscores the urgent need for improved coordination between health and social services, emphasizing the importance of integrated care models. The Social Return on Investment (SROI) framework is a valuable tool for evaluating the social, economic, and environmental impact of healthcare interventions, including integrated long-term care (LTC) solutions. However, a gap remains in reviews specifically analyzing its application to integrated LTC interventions. Objective : To examine how SROI has been used to evaluate integrated LTC interventions, particularly for older adults. Methods : A scoping review of peer-reviewed and grey literature was conducted, covering January 2012 to June 2024, through MEDLINE, CINAHL, Google Scholar, and citation searches. Three independent reviewers assessed study eligibility, following PRISMA guidelines. Data were extracted using PICOS terms and organized into summary tables detailing study characteristics and SROI findings. Results : Out of 556 screened papers, only 11 studies met the inclusion criteria, with most conducted in the UK. SROI evaluations focused on Personal and Community Resources, such as improved physical and mental health and social connections, while Public Resource benefits, including reduced healthcare workloads, were noted in seven studies. Financial proxies came from sources like HACT Social Value Bank and Global Value Exchange. All studies reported positive SROI ratios, though methodological limitations affect interpretation. Conclusions : The application of SROI to integrated LTC remains limited, primarily UK-based and reliant on context-specific methodologies. Expanding its use requires standardized methods, broader geographic representation, and localized proxies for more accurate evaluations.

The Effects of Private Equity Ownership in U.S. Nursing Homes Quality and Financial Performance: A Systematic Review

OREWA, G. N., KARABUKAYEVA, A., PRADHAN, R., *et al.*

2025

Health Policy 161: 105388.

https://doi.org/10.1016/j.healthpol.2025.105388

Background Private equity (PE) investment in U.S. nursing homes has increased significantly over the past two decades. The emergence of this novel ownership model has prompted concerns regarding its effects on nursing home performance, especially quality. Objective This systematic review examined the impact of PE ownership on U.S. nursing homes, focusing on quality of care and financial performance. The review was conceptually informed by agency theory and the structure-process-outcome (SPO) framework. Methods Following PRISMA guidelines, a systematic search across five databases identified 12 studies published between

2000 and 2024. Eligible studies examined the effects of PE ownership on nursing home quality or financial performance. Data were extracted and synthesized across these two dimensions. Results Across studies, PE ownership was linked to higher number of deficiencies, increased hospitalization rates, and higher mortality, although some improvements in care processes were noted. Financial outcomes showed initial financial gains but long-term challenges, primarily due to high debt loads. Conclusions Findings suggest that PE strategies may prioritize short-term profitability, which may compromise quality of care in some instances. These findings highlight the need for financial transparency, and reimbursement models that incentivize long-term quality.

Index des auteurs
Author index

A

B

C

D

E

F

G

H

I

J

K

L

M

N

O

P

Q

R

S

T

U

V

W

X

Y

Z