

Veille scientifique en économie de la santé

Watch on Health Economics Literature

Octobre 2026 / October 2026

Assurance maladie	<i>Health Insurance</i>
Démographie	<i>Demography</i>
E-Santé – Technologies médicales	<i>E-health – Medical Technologies</i>
Économie de la santé	<i>Health Economics</i>
Environnement et santé	<i>Environmental Health</i>
État de santé	<i>Health Status</i>
Géographie de la santé	<i>Geography of Health</i>
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Hôpital	<i>Hospital</i>
Inégalités de santé	<i>Health Inequalities</i>
Médicaments	<i>Pharmaceuticals</i>
Méthodologie – Statistique	<i>Methodology - Statistics</i>
Politique de santé	<i>Health Policy</i>
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Soins de santé primaires	<i>Primary Healthcare</i>
Systèmes de santé	<i>Health Systems</i>
Travail et santé	<i>Occupational Health</i>
Vieillesse	<i>Ageing</i>

Présentation

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

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Presentation

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Assurance maladie

Health Insurance

► Medicaid Expansion Through Ballot Initiatives Increased Medicaid Enrollment And Reduced Uninsurance Among Adults

BLAVIN, F., *et al.*

2026

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Between 2019 and 2021, six states expanded Medicaid through voter-approved ballot initiatives, overcoming legislative opposition. We used 2016–23 data from the American Community Survey to compare health insurance coverage outcomes in these six ballot initiative states with those in ten non expansion states. We estimated stacked event study regression models to account for variation in expansion timing and control for socioeconomic differences. Overall, ballot initiative expansions increased Medicaid enrollment by 3.2 percentage points and decreased uninsurance by 2.2 percentage points among nonelderly adults two years after expansion. Among low-income adults, Medicaid coverage increased by 10.1 percentage points, and uninsurance fell by 6.2 percentage points. These findings show that Medicaid expansions enacted through ballot initiatives significantly increased coverage, even in politically resistant environments. However, sustaining these gains may be difficult amid ongoing state-level opposition and new federal mandates. As opportunities for future ballot-driven expansions narrow, this study highlights both the potential and the limitations of direct democracy in advancing health policy.

► State Medicaid Programs Face Increased Spending On Medicare Premiums

FERNANDEZ, S., *et al.*

2026

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Medicaid covers Medicare premiums and out-of-pocket expenses for low-income older adults, who make up a growing segment of the US population. Using administrative data, we characterized the change in the number of beneficiaries dually enrolled in Medicare and Medicaid and corresponding changes in Medicaid spending on Medicare Part A and Part B premiums dur-

ing the period 2013–24. The number of dually enrolled beneficiaries increased by 27 percent, while Medicaid spending on Medicare premiums nearly doubled, primarily as a result of growing Part B premium spending. We estimated that at least half of the growth in Part B premium spending was attributed to the increasing per beneficiary Part B premium cost over time, with a smaller portion attributed to rising enrollment. Dual enrollment per capita increased in all but nine states. State Medicaid programs face a greater burden from rising Part B premium costs, yet they have little opportunity to control this spending without federal action.

► ACA Marketplace Take-Up Was High After Facilitated Enrollment In California; Disparities Remained

HAGEN, R., *et al.*

2026

Health Affairs 45(8): 934-942.

<https://doi.org/10.1377/hlthaff.2025.01585>

During the unwinding of the continuous coverage requirements related to the COVID-19 public health emergency in 2023, as an unprecedented volume of consumers were transitioning out of Medicaid, California launched a facilitated enrollment program for people who lost Medicaid and were eligible for subsidized Marketplace coverage. We conducted a survey in 2023–24 to assess coverage outcomes among Californians who lost Medicaid coverage, were assigned to a default plan, and had thirty days to opt in to coverage under the program. Although national surveys indicate high rates of uninsurance after loss of Medicaid, we found that 85 percent of those who were eligible for an Affordable Care Act Marketplace subsidy had some form of health insurance. Among those without other available coverage, nearly two-thirds opted in to a Marketplace plan. People with a high school education or less were least likely to enroll in Covered California, as were those who rated their health status as poor. Even after we accounted for premium amounts, income, education, health status, and language preference, take-up was higher among Asian/Asian American (84 percent) and White (79 percent) people than among Hispanic/Latino (53 percent) and Black/African American (54 percent) people. Our find-

ings indicate that facilitated enrollment interventions should be strengthened to overcome administrative and other burdens that persist among subpopulations.

► **Effects Of Medicare Advantage On Health Care Use And Outcomes Among Retired State Employees In 5 States**

HUCKFELDT, P. J., *et al.*

2026

Health Affairs 45(8): 880-887.

<https://doi.org/10.1377/hlthaff.2025.01693>

Medicare Advantage (MA) plans receive capitated payments that could lead to greater efficiency compared with traditional Medicare but may also curtail provision of beneficial services. However, MA effects are not fully understood, as most research to date is cross-sectional and could be subject to selection bias. This study investigated a natural experiment in which five states (Alabama, Arizona, Colorado, Connecticut, and New Jersey) shifted health benefits for retired state employees from supplemental plans for traditional Medicare to MA plans during the period 2017–19, leading to 87 percent of the more than 220,000 state retirees in these states shifting to MA. We found increased use of certain outpatient services (annual wellness visits and home evaluation and management visits) and observation stays, along with reduced hospital and postacute care admissions. We found no effect on days spent at home or in the community, or on mortality.

► **Long-Term Changes in Health Care Use and Outcomes Among Groups Maintaining Versus Losing Medicaid Upon Medicare Enrollment**

PALLIS, M., *et al.*

2026

The Milbank Quarterly 104(2): 534-551.

<https://doi.org/10.1111/1468-0009.70076>

Policy Points Our analysis indicated that permanent loss of Medicaid was associated with poorer health outcomes, higher mortality, greater out-of-pocket costs, and lower preventive health care use relative to those who kept Medicaid or had a temporary disruption. Addressing these coverage gaps can improve individual health and reduce systemwide costs. Policymakers should consider increasing eligibility criteria for Medicaid at age 65 years from 100% of the federal poverty level (FPL) to 138% FPL. Eligibility and

outreach efforts for Medicare Savings Plans or introducing state-level Medicaid income disregards from 100% FPL to 138% FPL could mitigate the Medicare Cliff in the absence of federal eligibility reform. **Context** About 280,000 older adults experience the ?Medicare Cliff? each year, becoming eligible for Medicare and losing Medicaid coverage when they turn age 65 years due to discontinuities in financial eligibility criteria. Yet, little is known about the long-term associations between a loss in Medicaid coverage and health status, health care utilization, and economic status in later life. Our study builds on previous research by longitudinally examining how health outcomes, health utilization measures, and out-of-pocket medical expenses change when people experience the Medicare Cliff compared with those who maintain their coverage and those who experience temporary disruptions in coverage. **Methods** Using longitudinal data from the Health and Retirement Study over the period 1998-2020, we tracked individuals over a 10-year follow-up period from when they first became eligible for Medicare. **Findings** Our analysis indicated that even though respondents with Medicaid prior to Medicare eligibility started with better health overall, permanent loss of Medicaid was associated with poorer health outcomes and higher mortality relative to those who kept Medicaid or had a temporary disruption. Permanent loss of Medicaid was also negatively associated with appropriate health care utilization and positively associated with higher out-of-pocket health care spending relative to those who kept Medicaid or had a temporary disruption. **Conclusions** Findings show that experiencing the Medicare Cliff is associated with a range of negative outcomes, including increases in overall health care expenditures relative to those who maintain Medicaid eligibility or only lose it temporarily. Addressing the Medicare Cliff issue would therefore lead to improved health outcomes and reduced health care costs. Our analysis provides a strong basis for policymakers to address this coverage discontinuity through specific policies related to Medicaid financial eligibility rules and access to Medicare Savings Plans to financially protect older adults.

Demography

► Faibles progrès de l'espérance de vie et contrastes marqués entre types de départements

BARBIERI, M.

2026

Population 80(3): 417-433.

<https://doi.org/10.3917/popu.2503.0417>

Le nombre de décès en 2024 s'établit à 646 000, soit une augmentation de 7 000 décès par rapport à 2023. Cette évolution n'est pas due à une dégradation de l'état de santé de la population, puisque l'espérance de vie à la naissance a continué à progresser en 2024 pour atteindre 80,0 ans pour les hommes et 85,6 ans pour les femmes, mais au vieillissement de la population. Les contrastes entre types de départements sont importants, avec une différence de durée de vie qui atteint 2,5 ans entre les départements d'outre-mer (Dom) et les départements urbains, les plus favorisés et qui bénéficient d'un avantage pour toutes les grandes catégories de causes de décès. Partout, cependant, les progrès de l'espérance de vie marquent un ralentissement depuis la fin du xxe siècle. La baisse de la mortalité par maladie cardiovasculaire continue à jouer un rôle déterminant dans la progression de l'espérance de vie tandis que la mortalité par cancer, première cause de décès en France depuis les années 1990, diminue plus lentement. L'évolution des morts violentes est plus préoccupante, de même que celle de la mortalité par maladie respiratoire pour les personnes âgées, avec une stabilisation à un niveau relativement élevé des taux de mortalité correspondants. En revanche, les tendances sont favorables pour les autres catégories de causes (maladies infectieuses non respiratoires et maladies du système digestif notamment).

► Une croissance démographique naturelle nulle pour la première fois depuis un siècle dans l'Hexagone

BARBIERI, M.

2026

Population 80(3): 323-332.

<https://doi.org/10.3917/popu.2503.0323>

Au 1^{er} janvier 2025, la France comptait 68,6 millions d'habitants, dont 2,3 millions dans les départements

d'outre-mer (Dom). La population continue de croître mais à un rythme qui se ralentit à cause, d'une part, de la baisse de la natalité, due à la fois à une diminution du nombre de femmes en âge de procréer et au recul de la fécondité et, d'autre part, de la hausse du nombre de décès, entraînée par le vieillissement de la population. À l'exception des Dom, où la croissance naturelle reste positive, l'Hexagone ne doit sa croissance démographique qu'aux migrations. C'est dans les départements ruraux que la croissance est la plus faible (0,1 % d'habitants en plus entre le 1^{er} janvier 2024 et le 1^{er} janvier 2025) et dans les Dom qu'elle est la plus élevée (0,4 % en plus au cours de la même année). Tous les départements sont affectés par un vieillissement de leur population mais celui-ci est particulièrement rapide dans les Dom, qui continuent toutefois à se caractériser par une structure par âge plus jeune qu'ailleurs.

► Une évolution démographique contrastée entre espaces ruraux et espaces urbains

BARBIERI, M., *et al.*

2026

Population 80(3): 315-321.

<https://doi.org/10.3917/popu.2503.0315>

► En France comme en Europe, le solde migratoire compense l'excédent des décès sur les naissances

PISON, G.

2026

Population et Sociétés(642)

En France en 2025, le nombre de décès, en hausse, a dépassé celui des naissances, en baisse. Cependant, la population a augmenté car le solde migratoire positif a plus que compensé le solde naturel négatif. De même, dans l'ensemble de l'Union européenne à 27 pays, les décès dépassent les naissances, mais la population est passée de 441 à 450 millions d'habitants entre 2012 et 2025 parce que son solde migratoire a plus que compensé jusqu'ici le solde naturel négatif.

► **Fécondité et infécondité en France : tendances, fluctuations et disparités territoriales**

THIERRY, X.

2025

Population 80(3): 375-396.

<https://doi.org/10.3917/popu.2503.0375>

En France, la fécondité diminue depuis 2011, et plus rapidement depuis 2019. La baisse a néanmoins été moins forte en 2024 qu'en 2023. L'indice conjoncturel de fécondité (1,62 enfant par femme en 2024) y est plus élevé qu'ailleurs en Europe. La proportion de femmes sans enfant a sensiblement augmenté, mais la

propension à avoir un deuxième ou un troisième enfant est assez stable depuis une quinzaine d'années. Si les femmes nées entre 1975 et 1985 sont susceptibles d'avoir un peu plus de deux enfants en moyenne, ce ne sera pas le cas des générations nées au début des années 1990. Le renouvellement des générations ne sera alors plus assuré. Le niveau de fécondité, en recul sur tout le territoire, n'est pas uniforme. En règle générale, il est un peu plus élevé dans les espaces ruraux à habitat dispersé que dans les petites villes, et dans les couronnes urbaines que dans les centres très denses. Toutefois, ces contrastes généraux sont moins marqués que les différences de niveau de fécondité entre cantons ruraux ou aires urbaines nommément désignés.

E-santé- Technologies médicales

E-Health – Médical Technology

► **Usage raisonné de l'intelligence artificielle générative dans la conduite et la rédaction des travaux académiques au cours des études de santé : élaboration d'une charte nationale française par la Conférence des doyennes et des doyens des facultés de médecine**

ANNWEILER, C., *et al.*

2026

Santé Publique 38(2): 11-21.

<https://doi.org/10.3917/pub.262.0011>

Contexte : L'intelligence artificielle (IA) générative transforme rapidement les pratiques académiques, pédagogiques et scientifiques. Dans les facultés de santé, son usage comporte des enjeux et soulève des défis pédagogiques, éthiques et réglementaires. Pour répondre à ces défis, la Conférence des doyennes et des doyens des facultés de médecine (CDD) s'est donnée pour objectif d'élaborer une charte nationale française encadrant l'utilisation de l'IA générative pour la conduite des travaux et la rédaction des rapports, thèses d'exercice et mémoires d'étude en santé. Méthodes : Consensus institutionnel conduit en trois phases : cadrage et analyse documentaire, corédaction itérative, consultation élargie et adoption officielle définitive. Les participants étaient tous des enseignants-chercheurs PU-PH, et la plupart doyennes et doyens de faculté de médecine. Résultats : La charte

se structure en six volets : principes généraux (usage complémentaire, transparence, traçabilité) ; usages autorisés (structuration, synthèse, relecture linguistique, traduction, code sous supervision) ; usages interdits (fabrication ou altération de données, plagiat, substitution à l'analyse critique, saisie de données sensibles dans des outils non souverains) ; responsabilités des étudiants, encadrants et institutions ; contrôle et sanctions ; perspectives et accompagnement. Le texte final a été adopté par la CDD en séance plénière le 26 novembre 2025 et sa diffusion nationale est en cours, via son adoption par chaque conseil de faculté. Conclusion : L'élaboration de cette charte illustre la volonté et la capacité des facultés de médecine à se doter d'un cadre commun face à une innovation technologique majeure. Ce processus collégial a permis de concilier innovation, pertinence pédagogique, intégrité scientifique et sécurité des données. La charte constitue désormais un référentiel national évolutif.

► **Quand les promesses rencontrent le terrain : l'appropriation d'un outil numérique de télésurveillance par les auxiliaires de vie au domicile de personnes en perte d'autonomie**

BENMARHIA, S. ET LECLERC, C.

2026

Revue Française des Affaires Sociales(1): 127-149.

<https://doi.org/10.3917/rfas.261.0127>

Le déploiement d'Onia, outil de télésurveillance basé sur l'intelligence artificielle, s'inscrit dans la promesse d'anticiper les fragilités des personnes âgées. Toutefois, les perceptions et modalités d'appropriation de cet outil par les auxiliaires de vie, principales utilisatrices, demeurent non encore étudiées. À partir d'une enquête qualitative (36 entretiens, 4 observations) menée dans cinq structures, l'article analyse comment cette innovation se reconfigure dans les usages des auxiliaires de vie. L'étude met en évidence des appropriations différenciées selon les contextes organisationnels et les modes de déploiement du dispositif. Si certaines auxiliaires y voient une valorisation de leur métier et un soutien à l'observation, d'autres dénoncent une surcharge ou une intrusion dans la relation de confiance avec les personnes accompagnées. Ce cas illustre l'écart entre promesses technologiques et pratiques situées : loin d'une adoption homogène, l'appropriation d'Onia relève d'un travail collectif de négociation, révélant que l'efficacité d'un outil numérique ne dépend pas seulement de son efficacité technique mais surtout de son inscription organisationnelle et de son usage quotidien.

► **Le deuxième avis médical dématérialisé : un outil de réduction des inégalités sociales de santé ?**

DEGRAVE, A. ET BRIFFAULT, X.

2026

Revue Française des Affaires Sociales(1): 229-248.

<https://doi.org/10.3917/rfas.261.0229>

Les services numériques d'avis médical promettent d'améliorer l'accès à l'expertise spécialisée dans un contexte marqué par l'allongement des délais pour accéder à une consultation, la persistance voire l'aggravation des déserts médicaux et l'intensification des inégalités sociales de santé. À partir d'une enquête auprès d'une entreprise française de deuxième avis médical dématérialisé, constituée par l'analyse de 17 342 dossiers médicaux, de 66 entretiens avec usagers et professionnels, d'une observation participante et de l'étude de documents internes, cet article examine dans quelle mesure ce dispositif contribue réellement à l'équité d'accès à la santé. Les résultats montrent une forte sélection socio-économique des utilisateurs, majoritairement jeunes ou d'âge intermédiaire, diplômés, familiers du numérique et résidant dans des zones médicalement pourvues. L'accès,

l'appropriation et les effets de l'avis reçu dépendent étroitement des ressources techniques, relationnelles et cognitives des patients, ainsi que de leur capacité à intégrer l'avis dans leur parcours thérapeutique. Si le service apporte des bénéfices substantiels, ceux-ci restent inégalement distribués, en accord avec les résultats de la littérature scientifique et les constats des rapports de santé publique nationaux. L'article discute enfin les conditions nécessaires à une opérationnalisation équitable du droit à l'expertise médicale.

► **L'intégration d'outils numériques dans le travail quotidien des aides à domicile : quelle mise en discussion ?**

KORNIG, C. ET PETRELLA, F.

2026

Revue Française des Affaires Sociales(1): 105-126.

<https://doi.org/10.3917/rfas.261.0105>

Le secteur de l'aide à domicile fait l'objet de nombreuses attentions de la part de la puissance publique, en raison du vieillissement de la population et de la faible attractivité des emplois qu'il propose. Si l'innovation y est fortement encouragée par les pouvoirs publics, les nouvelles technologies déployées visent le plus souvent à favoriser le maintien à domicile des bénéficiaires, et rarement à faciliter l'activité des aides à domicile. Cet article analyse les conditions d'introduction d'outils numériques au service de ces dernières, à partir d'une recherche qualitative menée sur deux ans et demi au sein d'une association d'aide à domicile. Il montre que les effets de ces outils sur le travail et sur les collectifs dépendent étroitement des modalités d'accompagnement. Il met notamment en évidence l'importance de discuter du travail réel et d'impliquer les salariées dans des processus itératifs d'ajustements et d'innovations.

► **Les relations télésoignants-patients dans l'écologie organisationnelle du soin : artefacts, trajectoires et professionnalisme**

MARRAST, P.

2026

Revue Française des Affaires Sociales(1): 319-338.

<https://doi.org/10.3917/rfas.261.0319>

Ce texte interroge les relations soignants-patients, dans un service de suivi téléphonique en oncologie, au prisme des artefacts de l'activité de soin qui équipent

le télésuivi et participent à la (re)configuration du travail infirmier et du travail sur soi des patients. Ces objets, créés, entretenus et (ré)agencés par les soignants, forment des ensembles que nous qualifierons de « composites du care » : des ensembles sociomatériels de procédures, supports et savoirs incorporés, qui structurent les trajectoires thérapeutiques, la planification des appels, la traçabilité et l'accompagnement à distance des patients. Dans le contexte du virage ambulatoire, une partie des compétences de soin (surveillance, traitements, coordination, effets secondaires) est progressivement déléguée aux patients, ce qui renforce leur responsabilisation mais les expose aussi à des inégalités de ressources ou de littératie médicale et numérique. Le télésuivi place ainsi les infirmières dans un entre-deux en tension entre les valeurs du professionnalisme organisationnel et celles du professionnalisme occupationnel, tensions que les composites du care permettent de négocier, de traduire et de rendre praticable au quotidien. Ces dispositifs, fruits d'un travail souvent invisible de couture et de maintenance, assurent un « tissu organisationnel bienveillant » qui relie les interactions à différentes échelles : échelle micro des relations interpersonnelles ; échelle méso du fonctionnement de service (protocoles, outils) ; et échelle macro des logiques gestionnaires et des politiques de santé.

► **Coverage with evidence development programs: a scoping review on characteristics and patient access**

VERBEEK, J. G. E., *et al.*

2026

Health Policy 171: 105615.

<https://doi.org/10.1016/j.healthpol.2026.105615>

Background Coverage with Evidence Development (CED) programs aim to balance early patient access to promising health technologies with robust evidence generation. However, whether these programs truly accelerate access and facilitate swift integration of health technologies into standard care remains unclear. **Objectives** This study evaluates CED characteristics, timelines from application to coverage decisions, and key factors influencing patient access. **Methods** We conducted a scoping review. Study eligibility was assessed by one reviewer and verified on a random sample by a second reviewer. Data extraction was performed independently by two reviewers. From the existing literature on patient access in CED programs, we identified factors affecting timely access. Additionally, we conducted an in-depth analysis of the longest and shortest CED programs for each type of health technology. **Results** Our search identified 2,839 peer-reviewed articles and grey literature sources. We examined 347 sources in this review, revealing 136 finalized CED programs across eight countries (1995–2025). The average time from application to coverage decision was 73.7 months (range: 6–215 months, SD: 36.6). We identified 18 factors influencing patient access, with early identification of decision uncertainties, horizon scanning, and active stakeholder engagement helping to accelerate the evaluation process. However, slow patient accrual often delayed early access. **Conclusions** CED programs vary widely in effectiveness, with delays in implementation affecting patient access. Systematic identification of decision uncertainties and streamlining evaluation processes are crucial for optimizing these programs. This study provides five key recommendations to enhance the efficiency of CED programs, ensuring that promising health technologies reach patients faster and more equitably.

Économie de la santé

Health Economics

► **Trends In US Health Care Spending By Income, 2005-23**

CLIFF, B. Q. ET MEILLE, G.

2026

Health Aff (Millwood) 45(7): 734-740.

<https://doi.org/10.1377/hlthaff.2025.01325>

From 2005 to 2023, per capita health care spending was highest and grew most rapidly among Americans in the top income quintile. During this period, age- and health-adjusted real spending grew 1.8 percent per year among people in the highest income quintile compared with no growth among people in the lowest income quintile. Differences among income levels were

most prominent in outpatient services and prescription drugs.

► **National Health Expenditure Projections, 2025–34: Strong Utilization Growth Initially, Legislative Impacts Later**

FIORE, J. A., *et al.*

2026

Health Affairs 45(7): 722-733.

<https://doi.org/10.1377/hlthaff.2026.00642>

By 2034, national health spending is projected to total nearly \$9.0 trillion and to represent 20.6 percent of the economy, compared with \$5.3 trillion and 18.0 percent in 2024. The rate of national health spending growth during this period is influenced by continued elevated use of medical services and goods through 2026; major legislative changes that affect insurance coverage and spending through 2028; and continued demographic shifts toward public programs, mainly Medicare. The insured share of the population is expected to be 90.5 percent in 2034, compared with 91.8 percent in 2024.

► **Integrating equity and productivity in health evaluation**

HANSEN, K. S., *et al.*

2026

Journal of Health Economics 108: 103156.

<https://doi.org/10.1016/j.jhealeco.2026.103156>

This paper develops a unified framework for evaluating health outcomes that jointly incorporates equity and productivity. Extending beyond traditional QALYs, PALYs, and the more recent PQALYs, we introduce a broader class of evaluation functions that integrate equity- and productivity-sensitive conditions. By imposing several normative criteria, including independence from measurement scales and Pigou–Dalton transfer principles, we obtain tractable power-form representations. In balancing equity and efficiency, the framework provides a coherent foundation for assessing interventions in contexts where both health and productive capacity are at stake.

► **The effect of offering standardized "Simple Choice" plans on premiums in the Federally Facilitated ACA marketplaces**

HOPKINS, B. ET LYONS, S.

2026

Journal of Health Economics 108: 103142.

<https://doi.org/10.1016/j.jhealeco.2026.103142>

Plan standardization policies aim to help consumers assess plan value by limiting variation in cost-sharing and directing attention towards premiums, networks, and formularies. They may also intensify issuer competition and lower premiums. We study one such policy—the introduction of standardized "Simple Choice" plans alongside non-standardized options in the 2017 ACA marketplaces—and estimate its effect on premiums. Across multiple identification strategies and robustness checks, we find that Simple Choice plans reduced premiums for bronze, silver, and gold tiers, including a 7.3% reduction in the benchmark premium.

► **Cost Effectiveness of Endovascular Thrombectomy for Large Ischemic Strokes: A US Healthcare Payer Markov Model Informed by Randomized Trials**

MORSI, R. Z., *et al.*

2026

Applied Health Economics and Health Policy 24(4): 777-789.

<https://doi.org/10.1007/s40258-026-01045-3>

Endovascular thrombectomy is standard for acute large-vessel occlusion stroke, but the value of endovascular thrombectomy in patients with large ischemic regions remains uncertain from a US healthcare payer perspective. This study evaluated the cost effectiveness of endovascular thrombectomy plus medical management (MM) versus MM alone in patients with large ischemic regions, synthesizing data from a recent meta-analysis of all available randomized trials.

► **Impact of prospective payment models on cancer patient care: a systematic review**

PÉREZ-ACEVEDO, J. J., *et al.*

2026

Health Policy 171: 105651.

<https://doi.org/10.1016/j.healthpol.2026.105651>

Background Cancer care faces increasing sustainabil-

ity challenges due to the structural growth of health care costs, driven by longer survival, expanding treatment indications, and the rapid diffusion of high-cost technologies. In this context, policymakers have implemented prospective payment systems (PPS) as policy strategies to promote care coordination, efficiency, and resource optimization in oncology. Objective To evaluate the association between the implementation of PPS and key outcomes in cancer care, including health care expenditure, service utilization, quality of care, and patient survival or mortality, compared with fee-for-service (FFS) payment models. Methods We conducted a systematic literature following PRISMA guidelines. Eligible studies, published between 2000 and 2024, assessed PPS mechanisms in adult cancer patient populations, mostly using cohort and case-control studies. We synthesized evidence across four predefined domains: health expenditures, service utilization, quality of care, and survival or mortality. Results Across included studies, findings were heterogeneous and context dependent. Nine studies evaluated health expenditures, of which 90 % reported reductions. Among six studies assessing service utilization, 66.7 % found no significant variation. Eleven studies examined quality outcomes; 54.5 % reported improvements. For survival, 57.1 % of seven studies showed favourable results. Conclusion Our review synthesizes the evidence on the implementation of PPS applied to cancer care compared with FFS models. PPS are consistently associated with cost containment, while evidence regarding utilization, quality, and survival remains mixed and, in some cases, inconclusive. Our findings underscore the potential of PPS as a policy instrument to improve financial sustainability in oncology, while also highlighting the need for careful design, implementation, and monitoring to mitigate unintended risks.

► **Health Economic Evaluations of Breast Cancer Screening Strategies: A Systematic Review Focusing on Methodology and Quality Assessment**

PHAM, T. H., *et al.*

2026

Applied Health Economics and Health Policy 24(4): 671-689.

<https://doi.org/10.1007/s40258-026-01049-z>

Breast cancer screening is vital for early detection and improved health outcomes but requires robust health economic evaluations to guide implementation. This systematic review examines the methodology, qual-

ity, and results of health economic evaluations of screening strategies to support decision making and future research.

► **Tele-triage, care substitution, and health: Evidence from quasi-randomly assigned nurses**

ROSE, L., *et al.*

2026

Journal of Health Economics 108: 103149.

<https://doi.org/10.1016/j.jhealeco.2026.103149>

Patients experiencing acute health symptoms often face uncertainty about how and where to receive care. We study patients who call a nurse advice line and receive one of four recommendations: emergency department (ED), urgent care (UC), primary care (PC), or self-care (Home). Leveraging an extension of examiner designs that recovers margin-specific effects for each pair of adjacent recommendations (ED-UC, UC-PC, PC-Home), we estimate the impact of nurse recommendations on both patient decisions and their subsequent health outcomes. We find that recommendations have large impacts on patient decisions at each margin. We then show that UC recommendations reduce 28-day healthcare costs by \$404 relative to ED recommendations and by \$247 relative to PC recommendations, suggesting substantial potential for cost savings through improved triage.

► **Regulated markets and rationalised myths: an institutional perspective on value-based purchasing in the Netherlands**

STEINMANN, G., *et al.*

2025

Health Economics, Policy and Law 21(1): 105-120.

<https://doi.org/10.1017/S174413312500012X>

In the Dutch health care system of regulated competition, health insurers are assigned the crucial role of prudent purchasers and expected to critically contract providers based on the quality and prices of their services. Thus far, however, these organisations have struggled to fulfil this role. This study sheds new light on the purchasing behaviour of Dutch health insurers. We examine how insurers perceive the context in which the value-based purchasing of hospital care should take shape, and we draw on insights from institutional theory to frame our analysis. Our findings are based

on a series of semi-structured interviews (n = 18) with employees and representatives of several insurer companies whose combined market shares add up to over 90 per cent of all premium payers. Our analysis highlights an environment in which market mechanisms are tangled up with historically rooted budgeting practices, where insurers are pressured to sustain rather than critique hospitals, and where self-regulating medical professionals are firmly supported by society's deep-seated belief in the quality of their services. Like many other organisations, Dutch health insurers tend to conform to their institutional environment. While this conformity may aid them in organisational stability and survival, it also restricts their ability to purchase prudently.

► **Do consumers perceive and trust health insurers within a system of managed competition as prudent buyers of care?**

STOLPER, K. C. F., *et al.*

2025

Health Economics, Policy and Law 21(1): 54-79.

<https://doi.org/10.1017/S1744133124000185>

In health care systems based upon the principles of managed competition, health Insurers are expected to act as prudent buyers of care. Consumers are expected to switch between insurers based upon the performance of insurers in this role. Yet, the Dutch experience shows that trust of consumers in health insurers is low and that switching consumers focus primarily on price. The question arises if consumers do in fact perceive and trust insurers as prudent buyers of care. We addressed this question by using a mixed-method approach. The results show that most people know that insurers buy health care and feel that the purchasing tasks suit their role. They even have reasonable, though fragile, trust in the purchasing competencies of the insurer. However, the results also revealed that consumers have insufficient information to cast a judgement about insurers as purchasers and incorrectly think that insurers are commercial organisations. Hence, improving the public information about insurers and their purchasing role seems to be crucial. Given the inherent complexity in the system, it remains to be seen if this objective can be reached in the (near) future. For that reason, policymakers should also consider additional measures to encourage that insurers will take integral purchasing responsibility.

► **The value of health and well-being from a societal perspective: A willingness to pay experiment in the Netherlands**

TRUJILLO JARA, K., *et al.*

2026

The European Journal of Health Economics 27(2): 259-276.

<https://doi.org/10.1007/s10198-025-01814-2>

Interpreting the results of cost-effectiveness analyses requires a threshold value for the costs per quality-adjusted life year (QALY). The first empirical studies that estimated this threshold value from a societal perspective in the Netherlands were conducted 10 years ago. This paper is aimed at estimating the social willingness to pay (WTP) per QALY and per well-being adjusted life year (WALY); investigating how the societal value of a QALY changed over the course of about ten years and comparing the WTP for well-being relative to health from a societal perspective. In this study, the contingent valuation approach was used, in which QALYs and WALYs were valued under uncertainty and corrected for probability weighting. The estimates obtained in a representative sample of the Dutch population ranged from €27,800 to €95,300 per QALY, depending on the specification of the societal perspective. The value of health found in the SOC and SII versions of this study, nominally, were between 6.1% and 33.4% higher than the values found 10 years ago. Moreover, the estimates per WALY ranged from €88,500 to €349,500. Finally, our results show that a year in full well-being was valued between 2.95 and 4.35 times higher than a year in full health.

► **The relationship between enrollees' perceptions of health insurers' tasks and their trust in them**

VAN DER HULST, F. J. P., *et al.*

2025

Health Economics, Policy and Law 21(1): 80-104.

<https://doi.org/10.1017/S1744133125000039>

Background: Health insurers' role in healthcare systems based on managed competition comprises various tasks. Misconceptions about these tasks may result in low public trust, which may hamper health insurers in performing their tasks. This study examines the relationship between enrollees' perceptions of health insurers' tasks and their trust in them. Methods: A questionnaire in November 2021 asked respondents to indicate to what extent health insurers have to perform

certain tasks, whether they actually perform them, and whether they think these tasks are important. Trust was measured using a validated multiple-item scale. The results from 837 respondents (56 per cent response rate) were analysed using multivariate regression models. Results: A larger mismatch between enrollees' expectations about health insurers' tasks and their actual statutory tasks is related to less trust regarding the categories 'controlling healthcare costs' and 'mediation and quality of care'. Second, a larger mismatch between expectations and actually performed tasks is related to less trust for all categories. Importance of tasks only affects this relationship concerning 'informing about price and availability of care'. Conclusions: This study emphasises the importance of reducing enrollees' misconceptions as trust in health insurers is necessary to fulfil their role as purchaser of care.

► The Opacity Of Price Transparency

WEHRLY, D. V., *et al.*

2026

Health Affairs 45(6): 614-621.

<https://doi.org/10.1377/hlthaff.2025.01530>

The success of price transparency initiatives requires that prices be defined using a common payment methodology. In this article, we explore how coding schemas and pricing approaches varied in five major markets in the United States in 2024. We investigated how frequently inpatient and outpatient payment were based on the use of Medicare Severity Diagnosis Related Group (MS-DRG) or Healthcare Common Procedure Coding System (HCPCS) codes with fixed prices versus alternative methods, such as per diem revenue codes or a percentage of billed charges for all services. We estimated that fixed-price MS-DRG or HCPCS methods were used for a preponderance of services in only 48 percent of inpatient contracts and 53 percent of outpatient contracts in 2024. Within markets, carriers seldom used fixed-price contracts for all hospitals. Similarly, most hospitals were not paid using fixed-price methods by all carriers. These results suggest that price comparisons by consumers, employers, academics, and other stakeholders face significant barriers because of the heterogeneity of payment methodologies. Moreover, efforts to promote price transparency will also need to confront the heterogeneity in pricing approaches when trying to present prices across different hospitals.

► Equity of financial protection for health care in high-income countries: A systematic scoping review

XIE, E. C., *et al.*

2026

Social Science & Medicine 402: 119306.

<https://doi.org/10.1016/j.socscimed.2026.119306>

Background Financial protection is a central objective of health systems and a key mechanism for advancing health equity within universal health coverage. To date, evidence on the equity of financial protection in high-income countries has not been systematically synthesized. Objective To summarize the literature on the equity of financial protection for health care in high-income countries. Methods We conducted a systematic scoping review based on a published protocol. We searched four academic (Embase, MEDLINE, IBSS, EconLit) and three grey literature (WHO, OECD, World Bank) databases for data addressing four domains: (i) variables used to characterize equity, (ii) financial protection indicators, (iii) observed financial protection distributions, and (iv) conceptualizations of equity. Eligible records were original research published in any language since 2010. Two reviewers independently assessed records for eligibility. Findings were synthesized narratively. Results Seventy-five records were included from 4142 screened results, covering data from 48 countries. The largest number of studies focused on the Republic of Korea (n = 13) and the United States (n = 11). Inequalities of financial protection were observed for at least one determinant of health in each setting, across diverse indicators and individual or group stratifiers. Most studies insufficiently conceptualized equity, limiting assessment of outcomes as equitable or inequitable. Notable gaps include the underrepresentation of important variables (e.g. migration status, area-level deprivation, and social class), minimal examination of disproportionate advantage, and the inconsistent application of more equity-sensitive analytical methods. Conclusion This review provides the first systematic synthesis of evidence on the equity of health system financial protection in high-income countries. Key issues that warrant attention in future research and practice include clearer conceptualization of equity and the analysis of underrepresented determinants of health and disproportionate advantage.

Environnement et santé

Environmental Health

► **Les inégalités sociales au cœur des politiques de transition : entre contraintes structurelles et justice sociale**

DUBUISSON-QUELLIER, S.

2026

Regards Croisés sur l'Economie n° 38(1): 235-245.

<https://doi.org/10.3917/rce.038.0235>

La transition écologique est souvent réduite à des enjeux techniques ou comportementaux, occultant les inégalités sociales qui en conditionnent la réussite. Trois types d'inégalités – contribution aux émissions de gaz à effet de serre (GES), exposition aux risques climatiques et efforts imposés par les politiques de transition – révèlent que les ménages les plus précaires, bien que contribuant le moins au changement climatique, en subissent le plus les impacts et les contraintes. Ces inégalités, structurelles et territoriales, remettent en cause l'efficacité et la légitimité des politiques climatiques lorsqu'elles ignorent les réalités socio-économiques. Pour être justes et efficaces, ces politiques doivent intégrer une dimension sociale forte : faciliter l'accès aux solutions bas-carbone, protéger les populations vulnérables et repenser les normes écocitoyennes pour éviter une polarisation sociale et un rejet des mesures environnementales.

► **Impact des dispositifs médicaux dans l'empreinte carbone d'une unité de chirurgie ambulatoire : état des lieux et perspectives de décarbonation**

JOUHET, O., *et al.*

2026

Annales Pharmaceutiques Françaises 84(4): 749-759.

<https://doi.org/10.1016/j.pharma.2026.01.002>

Résumé Le secteur de la santé représente 8 % des émissions de gaz à effet de serre (GES) en France parmi lesquelles 30 % sont dues à l'achat de dispositifs médicaux (Tennison *et al.*, 2021). Le groupement hospitalier souhaite évaluer l'empreinte carbone (EC) de plusieurs parcours de soin dans les unités de chirurgie ambulatoire (UCA). L'objectif du travail est d'évaluer l'empreinte carbone de l'UCA pour identifier les postes les plus émetteurs de GES. Les données d'activité de l'EC

de l'UCA ont été recueillies pendant deux semaines en 2023 par une équipe pluri-professionnelle et converties en données d'émissions par des facteurs d'émission. Les émissions de GES liées aux consommations en eau, énergie, aux déplacements des patients et personnels, à la maintenance et aux achats d'équipements en 2022, à l'achat des produits de santé, à la pesée des déchets ont été mesurées. En 2022, l'UCA a émis 684 tonnes (t) CO₂ pour 4884 interventions, soit 140kg eCO₂ par opération. Les émissions engendrées par les achats de dispositifs médicaux à usage unique stériles (DMUUS) sont de 52 %, équipements 15 %, énergie 8 %, dispositifs médicaux re-stérilisables (DMRS) 6 %, déplacement du personnel 5 %, transport des patients 2 % et les déchets 2 %. L'achat de DMUUS est le plus émetteur de GES à l'UCA. Plusieurs actions de développement durable, déjà mises en place (sévoflurane à faible débit, tri des déchets en salle d'opération) doivent s'accompagner de nouveaux projets portant sur l'achat de DMUUS.

► **Valuing reductions in the risk of death in benefit–cost analyses of environment–and climate–health actions**

PEGA, F., *et al.*

2026

Bulletin of the World Health Organization(104): 246-258.

Economic evaluation is key for efficient allocation of resources in health and related sectors. Actions addressing environmental risk factors and climate change can avert millions of deaths annually, yet valuing reductions in the risk of dying is challenging in benefit–cost analyses. We developed an interim statistical protocol to estimate the value per statistical life for World Health Organization (WHO) Member States, building on the 2019 benefit–cost analysis reference case and latest evidence. Using gross national income per capita based on purchasing power parity, we calculated national estimates for 2024 and projected values to 2100. We aggregated these estimates to produce global, regional and country income group averages, and additional sets for sensitivity and scenario analyses, including for alternative climate change scenarios. Our estimates cover 93.8% (182/194) of Member States, representing 98.4% (7.99 billion/8.12 billion) of

the global population. The global average value per statistical life in 2024 was 3.76 million international dollars. By 2100, the global average is projected to increase by 159.8% to 9.77 million international dollars. These estimates provide a basis for valuing expected deaths averted by environment- and climate-health interventions, promoting comparability across analyses. Limitations include reliance on extrapolated values and uncertainty in income projections. More research, especially in low- and middle-income countries, is needed. Because value per statistical life estimates depend on income, analysts must supplement benefit-cost analysis with distributional analyses of benefits and costs across populations. Until WHO updates its recommended methods, these interim estimates offer a pragmatic tool for policy analysis.

► **Aligning Health Policy With Climate Action: Evidence-Based Interventions To Decarbonize Care, Improve Climate Resilience**

WHEAT, S., *et al.*

2026

[Health Affairs 45\(5\): 498-506.](#)

<https://doi.org/10.1377/hlthaff.2025.01635>

The US health care system significantly contributes to climate change while increasingly facing its adverse consequences. Despite this dual challenge, policy efforts to incentivize carbon reduction and make care delivery climate-resilient remain fragmented. In this article, we identify policy interventions and other strategies that have the potential to accelerate the transition toward low-carbon, climate-smart health care systems. Drawing on academic literature and real-world implementation examples, we present a framework of strategies, highlighting the evidence in support of mechanisms such as green reimbursement models, integration of climate change into health professional education, and sustainable procurement standards. We further examine emerging policy levers, including circular economy practices and mandated carbon accounting. Last, we highlight opportunities for federal and state policy makers, payers, and health system leaders to guide future action. Ensuring that health policies actively support climate mitigation and adaptation is a moral and environmental imperative and a strategic opportunity to improve quality, reduce costs, and advance health equity.

État de santé

Health Status

► **Cocaïne : quand le groupe fait le risque**

ARUTKIN, M. ET VALLÉE, A.

2026

[Santé Publique 38\(2\): 23-27.](#)

<https://doi.org/10.3917/spub.262.0023>

L'usage de la cocaïne en France a fortement augmenté au cours des deux dernières décennies, s'accompagnant d'une hausse documentée de la prévalence, des passages aux urgences et des hospitalisations pour complications somatiques et psychiatriques. Cette diffusion ne suit pas une dynamique homogène mais s'organise autour de réseaux sociaux, de contextes festifs spécifiques et de temporalités critiques, en particulier la fin de nuit (*after-parties*) et les soirées privées, qui semblent jouer un rôle central dans l'initiation et la normalisation des usages. En s'appuyant sur les concepts de l'épidémiologie et de la théorie

des réseaux, la cocaïne peut être analysée selon une analogie épidémiologique, où sa diffusion dépend d'un seuil de propagation sociale lié aux interactions interpersonnelles et au renforcement par les pairs. Les interventions structurelles ciblant les nœuds et ponts du réseau, telles que l'amélioration des transports nocturnes — susceptible de réduire certaines transitions à risque en fin de nuit — apparaissent comme des leviers potentiels pour la prévention en santé publique.

► **Change in healthcare resource use and associated costs of patients with metastatic lung cancer between 2013 and 2021: an observational study from the French national health data system**

CHOUAID, C., *et al.*

2026

The European Journal of Health Economics 27(4): 881-891.

<https://doi.org/10.1007/s10198-025-01864-6>

Treatment landscape in metastatic lung cancer has progressed quickly over the last decade, mainly due to immunotherapies and targeted therapies. This study aimed to describe changes in costs associated with metastatic lung cancer in France.

► **Rédaction d'un modèle de directives anticipées approprié pour les femmes atteintes d'un cancer du sein : méthode Delphi**

FRÈCHE, B., *et al.*

2026

Santé Publique 38(2): 203-215.

<https://doi.org/10.3917/spub.262.0203>

Introduction : Le cancer du sein, premier cancer féminin, touche aussi les femmes jeunes. Les directives anticipées permettent à un sujet d'exprimer ses volontés concernant sa fin de vie. Seuls 21 % des Français de plus de 75 ans les ont rédigées. Ceci s'explique notamment par le fait que les Français ne se sentent pas forcément concernés par les directives anticipées. Les médecins généralistes évoquent de vraies difficultés à parler de fin de vie avec leurs patients. Méthode : Nous proposons ici un modèle de directives anticipées adapté aux femmes atteintes de cancer du sein, issu d'un consensus d'experts. Ce consensus a été obtenu en trois rondes Delphi grâce à l'évaluation des 21 experts. Résultats : Le résultat est un document qui se veut être un témoignage fidèle de la personne qui le rédigera, abordant à la fois ses valeurs morales, ses volontés concernant les soins médicaux et ses souhaits d'accompagnement Discussion : Ce modèle permet d'ouvrir un échange entre le médecin et sa patiente et se veut un témoignage fidèle de ses souhaits. Il sera très intéressant de proposer le modèle de DA créé aux patientes afin de recueillir leur opinion et de le réadapter en fonction de leurs remarques.

► **Long-term costs associated with healthcare use of people with cancer in Scotland**

HAINING, K., *et al.*

2026

The European Journal of Health Economics 27(1): 1-15.

<https://doi.org/10.1007/s10198-025-01800-8>

Evidence for the long-term costs of cancer is limited, particularly in the Scottish population. Our aim was to better understand the long-term healthcare use and associated costs of cancer in Scotland, and their relationship with cancer survival.

► **Early dynamics of multimorbidity in 17.4 million people in Spain: onset patterns and prognostic value**

IOAKEIM-SKOUFA, I., *et al.*

2026

European Journal of Public Health 36(3).

<https://doi.org/10.1093/eurpub/ckag067>

Multimorbidity, the coexistence of two or more chronic diseases, has become a defining challenge for ageing societies. Yet evidence on when and how chronic diseases begin to cluster, and on the prognostic importance of this timing, remains limited. We used nationwide primary care electronic health records covering 17.4 million people in Spain to reconstruct the onset and progression of chronic disease over the life course. The first recorded diagnosis was used to trace temporal trajectories of multimorbidity by age and sex. We examined how the first condition, age at diagnosis, and time since that diagnosis were associated with advanced (≥ 3 diseases), multisystem (≥ 2 organ systems), and complex multimorbidity (≥ 3 organ systems), as well as premature mortality (< 50 and < 65 years) and outcomes related to polypharmacy and high-risk prescribing, using multivariable regression and gradient boosting models. By 2021, more than one in three Spaniards lived with a chronic condition, and over half of adults aged 45 years or older had multimorbidity. Among them, nearly 60% had complex multimorbidity. The time elapsed since the first diagnosis showed the closest link to further accumulation, followed by age at first diagnosis and current age. Later onset, particularly after the mid-50s, was associated with faster decline once disease emerged. The timing of the first chronic condition is a powerful but often overlooked prognostic marker. Public health strategies delaying onset and integrating early management could substantially reduce the long-term burden of multimorbidity in European populations.

► **Trends in physical and mental health needs across generations in Australia**

LENZEN, S., *et al.*

2026

The European Journal of Health Economics 27(1): 95-116.

<https://doi.org/10.1007/s10198-025-01791-6>

Despite evidence of changes in age-specific incidence and prevalence rates for chronic conditions and disease, future health resource planning is often based on historical age- and gender-specific service use, neglecting changes in the need for care within age groups between generations. This paper studies differences in health needs by age and gender across birth cohorts in Australia and considers the implications for future health service planning. Whilst controlling for age and period effects, we find that more recent-born female birth cohorts have higher prevalence rates of long-term health conditions than earlier-born cohorts, whereas we don't find an effect for males. The increase for females corresponds with an increase in probable mental disorders, and while we also find an increase in probable mental disorders among males, decreases in physical impairment rates among both genders offset the overall rates of long-term health conditions among males but not among females, where increases in probable mental disorders are larger. Comparing projections of mental health service requirements that integrate cohort effects, as opposed to those that do not, shows that traditional planning models may underestimate health service requirements for the future. Our findings suggest that health service planners should relax assumptions about constant age-specific use.

► **Associated determinants of smoking among immigrants and descendants of immigrants in France in the Covid-19 period**

MACNEIL, P., *et al.*

2026

Journal of Epidemiology and Population Health 74(3): 203389.

<https://doi.org/10.1016/j.jep.2026.203389>

Background Previous findings have indicated that immigrant smoking behaviour differs from that of the native-born population. However, certain factors identified as predictors among the general populations, such as social norms and religion, are seldom examined among immigrants. This study aims to

identify demographic, social norm and religion-related determinants associated with smoking among immigrants and descendants of immigrants in the French context. **Methods** A sample of immigrants and descendants of immigrant(s) in France completed a cross-sectional online survey in 2020. Data was collected on factors hypothesized to be determinants of smoking. Associations between selected covariates and smoking were quantified through multivariable logistic regression analyses. Comparability of the study sample with the source population was also assessed. **Results** Sex-specific immigrant and descendant analyses revealed variation between these groups in demographic and other predictors of smoking. High odds of smoking were noted among male and female descendants of Middle Eastern and other North African origin, descendants who indicated that not smoking had negative social consequences and among female immigrants with an insufficient health literacy status. Lower odds of smoking were noted among female descendants of immigrants who practiced a religion. **Conclusion** These findings underlined the need for the inclusion of seldom-studied key determinants of smoking such as religion and social norm factors in development of smoking prevention and cessation programs that target immigrants and descendants of immigrants in France.

► **Predicting childhood overweight and obesity at school entrance using healthcare, demographic, and socioeconomic data in Wales, UK**

ZIAUDDEEN, N., *et al.*

2026

European Journal of Public Health 36(3). ckag051

<https://doi.org/10.1093/eurpub/ckag051>

In Wales, 24.8% of children aged 4–5 years live with overweight/obesity. Obesity is linked to developing multiple long-term conditions. We aimed to predict childhood obesity using healthcare and wider demographic, socioeconomic, and area-level data. The Secure Anonymized Information Linkage (SAIL) Databank in Wales contains routinely collected individual-level anonymized data from health records and administrative data. Two subsamples were created. The first restricted to singleton births between 15 March 2010 and 28 March 2012 to include Census 2011 data. The second included births after 1 January 2014 to include early-life measurements. Age- and sex-adjusted body mass index (BMI) at 4–5 years was used to define out-

come of overweight/obesity (≥ 91 st centile). Backward stepwise logistic regression models with multivariable fractional polynomials were used to develop models in stages. Data were available on 53 815 children at 4–5 years in census and 60 990 children in early-life subsample. Maternal BMI, smoking, marital status, birthweight, ethnic group, gender, and breastfeeding at birth were retained in all models. Additional variables were retained on adding census and area-level factors but increase in discrimination (Area Under the

Curve, AUC) was marginal (0.66–0.67). In the second subsample, AUC improved from 0.67 to 0.79 as factors up to weight at 27 months were incorporated. Factors from healthcare records were largely consistent with existing literature. Additional insights were provided by including census data, though increase in model discrimination was marginal. Childhood obesity can act as a mediator on the pathway to multiple long-term conditions, and risk identification tools may target early prevention.

Geography of Health

► Association between neighborhood social cohesion and depressive symptoms: findings from the CRONICAS Cohort Study

BERNABE-ORTIZ, A., *et al.*

2026

Health & Place 100: 103709.

<https://doi.org/10.1016/j.healthplace.2026.103709>

Purpose While the protective role of neighborhood social cohesion against mental disorders is well-documented in high-income countries, evidence from resource-constrained settings remains scarce. This study evaluated the cross-sectional and longitudinal associations between neighborhood social cohesion and depressive symptoms in a Peruvian cohort. **Methods** Data from the CRONICAS Cohort Study were analyzed. The primary outcomes were the prevalence and incidence of depressive symptoms, assessed via the Center for Epidemiologic Studies Depression Scale (CES-D). Neighborhood social cohesion, conceptualized through trust, reciprocity, and solidarity, was measured using a 4-item scale and categorized into tertiles. Single variable and multivariable-adjusted Poisson regression models were used to estimate incidence rate ratios (IRR) and 95% confidence intervals (95% CI). **Results** Among 3533 participants (mean age 55.8 ± 12.7 years; 51.5% female), baseline prevalence of depressive symptoms was 18.6% (95%CI: 17.3%–19.9%). Middle and high levels of social cohesion were associated with a 27% (95% CI: 13%–38%) and 47% (95% CI: 19%–66%) lower prevalence of symptoms at baseline. We identified 221 incident cases (4.0 cases per 100 person-years, 95% CI: 3.5–4.6). High social cohesion was associated

with an adjusted 46% (95% CI: 9%–68%) reduction in the risk of developing depressive symptoms over 30 months. **Discussion** Higher neighborhood social cohesion was significantly associated with a reduced prevalence and a lower incidence of developing depressive symptoms. These findings suggest that interventions aimed at fostering community trust and social capital may represent a viable strategy for mental health prevention in resource-constrained environments.

► Longitudinal studies of neighbourhood social cohesion and mental health: a systematic review with meta-analysis

BLAIR, D. L., *et al.*

2026

Health & Place 100: 103702.

<https://doi.org/10.1016/j.healthplace.2026.103702>

Objectives This review aimed to examine how neighbourhood social cohesion has been defined and operationalized in longitudinal mental health research, and determine its associations with depression, anxiety, suicidality, psychological distress, and positive mental health across the life course. **Methods** Relevant articles were identified on February 6, 2024, in Medline, Embase, PsycINFO, CINAHL, and Web of Science. Eligible studies used quantitative longitudinal designs. Risk of bias was assessed using the Newcastle-Ottawa Quality Assessment Scale for Cohort Studies (NOS). Included articles were synthesized using direction of effect narrative synthesis and random-effects meta-analysis. Reporting was guided by the PRISMA-2020 state-

ment. Results Narrative synthesis included 42 articles representing 30 independent study samples, with the majority of articles on depression ($n = 26$). Out of a maximum score of nine, the median NOS score was seven (interquartile range = 2, range = 5, 9); higher scores indicate lower risk of bias. Overall, based on direction of effect, 28 articles reported positive associations between neighbourhood social cohesion and better mental health outcomes (17 were statistically significant). Meta-analysis of 12 depression articles found that higher neighbourhood social cohesion was associated with lower depression scores ($n = 62,677$, $\beta = -0.054$, 95%CI = $-0.091, -0.018$). Conclusion Higher neighbourhood social cohesion is longitudinally associated with lower risk of depression; evidence for other mental health outcomes remains limited. While multi-item scales have been widely used to capture the multidimensional nature of neighbourhood social cohesion, no single definition of neighbourhood or method of measuring neighbourhood social cohesion was consistently used. Efforts towards establishing a consensus would enhance comparability.

► **Mesurer l'hétérogénéité territoriale de l'accessibilité aux soins : aller au-delà de l'APL**

CHÉRON, A., *et al.*

2026

Santé Publique 38(2): 189-202.

<https://doi.org/10.3917/spub.262.0189>

Introduction : L'accessibilité aux soins primaires constitue un enjeu majeur de santé publique en France. L'accessibilité potentielle localisée (APL), considérée comme l'indicateur de référence pour identifier les territoires en tension, fournit une mesure indirecte du déséquilibre entre l'offre et la demande de soins. L'objectif de cette étude est de proposer un indicateur complémentaire, fondé sur l'acceptation de nouveaux patients par les médecins généralistes, afin de mieux caractériser les inégalités territoriales d'accès aux soins. Méthodes : Nous exploitons des données originales issues de plateformes de prise de rendez-vous médicaux en ligne, couvrant près de 12 000 médecins généralistes et plus des deux tiers de la population française. Nous déterminons, à l'échelle communale, la proportion de médecins généralistes acceptant de nouveaux patients (PNP), en utilisant une méthodologie comparable à celle de l'APL. Résultats : Les disparités territoriales apparaissent plus marquées lorsqu'elles sont mesurées par la PNP que par l'APL. Selon les dif-

férentes mesures de dispersion retenues, l'hétérogénéité territoriale est deux à trois fois plus élevée avec la PNP. Des discordances substantielles sont observées entre les deux indicateurs : pour 8,61 % des communes (15,35 % de la population), l'APL sous-estime les difficultés d'accès aux soins, tandis que pour 11,19 % des communes (22,28 % de la population), elle les surestime relativement à la PNP. Conclusion : La PNP constitue un indicateur direct et synthétique du déséquilibre entre l'offre et la demande de soins. Complémentaire à l'APL, la PNP permet d'affiner l'identification des territoires en tension et de mieux cibler les politiques publiques visant à réduire les inégalités territoriales d'accès aux soins. Ces résultats plaident en faveur d'une généralisation de la collecte et de l'exploitation de la PNP afin d'en faire un critère central d'analyse du déséquilibre entre l'offre et la demande de soins, et un outil d'aide au ciblage des politiques publiques.

► **Les déterminants à l'installation des médecins généralistes dans la Loire**

DARQUE, V., *et al.*

2026

Médecine 22(4): 180-186.

<https://doi.org/10.1684/med.2026.1192>

Contexte. La question des déterminants de l'installation des médecins généralistes (MG) constitue un enjeu central pour comprendre les disparités territoriales de la démographie médicale. Cette étude vise à analyser les déterminants de l'installation des MG au cours de la dernière décennie et à évaluer l'impact des politiques incitatives. Méthodes. Une étude mixte a été menée. Sept entretiens semi-directifs auprès de MG installés depuis moins de dix ans ont permis l'élaboration d'un questionnaire qui a été diffusé à l'ensemble des MG de la Loire grâce au Conseil Départemental de l'Ordre des médecins. Résultats. Les déterminants familiaux apparaissent comme prépondérants avec 73 % des médecins ($n = 56$) citant des motivations personnelles et 79 % estimant que le projet familial primait sur le projet professionnel. Les expériences professionnelles antérieures s'étaient montrées déterminantes pour 48 % des médecins. Parmi les MG installés en zone sous-dense (30 %), 88 % avaient réalisé un stage dans les mêmes conditions. L'exercice de groupe était privilégié (66 %), ainsi que la proximité d'un hôpital. L'ancrage territorial était marqué : 68 % des médecins résidaient dans la Loire avant leurs études et 80 % y ont effectué leur deuxième cycle. Les déterminants financiers apparaissent secondaires. Conclusion. Le territoire est appar-

davantage comme un facteur de rétention que d'attractivité externe. Le renforcement du recrutement local des étudiants en médecine, la favorisation de l'exposition aux stages ruraux durant l'internat et une simplification de l'accès à l'information sur l'installation constituaient des leviers prioritaires pour favoriser une installation en zones sous-dotées.

► **Environmental phenotypes for healthy weight in children using population-based linked environment and health data: a cross-sectional observational study**

DAVIES, J., *et al.*

2026

Health & Place 100: 103681.

<https://doi.org/10.1016/j.healthplace.2026.103681>

Background Childhood obesity is a major global health challenge, projected to affect one in three children worldwide by 2050. While individual and social factors contribute, increasing evidence highlights the built environment as a key determinant in shaping children's behaviours and weight outcomes. Evidence suggests that neighbourhood design, greenspace access, and food retail availability influence diet and physical activity, but most studies rely on small samples or single-domain measures. **Methods** We linked nationwide geographic information systems (GIS) data describing residential neighbourhoods with objectively measured child weight from a national Welsh surveillance programme for children aged 4–5 years. Using multiple indicators—including housing type, garden size, neighbourhood greenness, walkability, access to recreational spaces, and food outlet density - latent class analysis was used to identify distinct "environmental phenotypes". Associations between phenotypes and child weight status were examined using logistic regression. **Results** We identified discrete classes of residential environments characterised by varying combinations of built and food environment features. The model with five classes was the best fit overall, with percentage and number of households in each phenotypes: Rural, spacious and isolated 14% (24,266), Suburban 17% (29,324), Deprived and under-served 23% (39,227), Deprived and well-served 32% (53,210), and Dense, coastal and well-connected 13% (21,762). Children living in rural, spacious and isolated neighbourhoods, characterised as those with greater greenspace, private gardens, and walkable layouts, had significantly lower odds of overweight and obesity (OR = 0.89, CI = 0.86-0.93), whereas those in deprived

and well-served neighbourhoods, characterised by high-density housing areas with limited greenspace and high fast-food outlet density, had elevated risk (OR = 1.09, CI = 1.06-1.13). These associations remained robust after adjustment for area-level deprivation and rurality. **Conclusion** Our findings highlight the importance of the residential environment in early childhood obesity risk. Nationally linked GIS and health data enable robust classification of obesogenic environments, informing urban planning and public health strategies to promote healthier, child-friendly neighbourhoods.

► **Inégalités socio-territoriales de vaccination contre la grippe : accessibilité des soins, revenus et santé des individus âgés**

DHUOT, R.

2026

Santé Publique 38(2): 103-118.

<https://doi.org/10.3917/spub.262.0103>

Introduction : En France, les individus de 65 ans et plus présentent des taux de vaccination antigrippale (VAG) inférieurs aux objectifs de santé publique. L'explicitation des facteurs structurels de la VAG peut apporter des informations utiles aux campagnes de prévention. **Méthode :** Cette recherche s'appuie sur des données agrégées au niveau départemental issues de la statistique publique. Les variations des taux de VAG des individus de 65 ans et plus, entre 2016 et 2022, sont estimées par régressions linéaires multiples selon les évolutions de leurs revenus médians, de leur taux de pauvreté, d'indicateurs de santé et d'activité physique, ainsi que de la disponibilité des médecins généralistes sur les territoires. Afin de contrôler l'hétérogénéité inter-individuelle, des effets fixes individuels et temporels sont ajoutés. Des écarts-types robustes sont calculés selon la méthode de White. **Résultats :** Une augmentation d'un point de leur taux de pauvreté est associée à une diminution du taux de VAG des 65 ans et plus de 1,06 % ($p < 0,001$) ; une augmentation de leur taux de passage aux urgences pour syndrome grippal d'un cas pour 10 000 est associée à une augmentation de leur taux de VAG la saison suivante de 0,004 % ($p < 0,001$) ; une amélioration de l'accessibilité aux médecins généralistes d'une consultation par personne et par an est associée à une élévation du taux de VAG des 65 ans et plus d'1,56 % ($p < 0,01$). L'effet de l'accessibilité diminue à mesure que le revenu médian des 65 ans et plus s'élève ($p < 0,001$) et que leur santé s'améliore ($p < 0,01$). **Conclusions :** Une approche socio-territoriale des

facteurs de la VAG des individus âgés peut contribuer à la fois au dimensionnement des politiques de santé publique et, de manière plus modeste, à l'explicitation des ressorts de la VAG.

► **Fragilités et enjeux de santé spécifiques des territoires ruraux français**

FAYET, Y., *et al.*

2026

Santé en Action (la)(472): 8-9.

Marqués par différentes fragilités socio-économiques et démographiques ou d'accessibilité, les territoires ruraux présentent globalement des indicateurs sanitaires défavorables, mais qui cachent une grande diversité de causes et de situations. L'adaptation des actions locales à ces vulnérabilités est essentielle, de même qu'une approche globale pour intervenir de concert sur les environnements et les habitudes de vie au sein de ces territoires.

► **Lonely in place? The intersection of loneliness and place in the chronic illness experience**

LINDEGAARD MOENSTED, M., *et al.*

2026

Health & Place 100: 103712.

<https://doi.org/10.1016/j.healthplace.2026.103712>

Place significantly impacts health and belonging, yet little is known about how place and loneliness intersect for people with chronic conditions. This qualitative study examined how people with chronic illness experience places in their daily lives, and how these place-based experiences shape feelings of loneliness. We conducted in-depth interviews, walking interviews and photo-elicitation with 40 participants across urban and regional Australia, analysing how place relationships intersected with loneliness and illness experiences. Our analysis revealed three distinct patterns. 'Effortless belonging' characterised those with pre-existing advantages (spatial stability, economic security, established networks) who maintained unconscious protective buffers against loneliness through deep place familiarity despite illness. 'Strategic spatial negotiation' described participants who actively curated place engagement – using home as refuge during symptomatic periods while selecting accessible public spaces to maintain social identity. "Geographic disenfranchisement" emerged where chronic illness compounded structural vulner-

abilities (poverty, housing instability, marginalisation) creating compromised place connections where locality intensified rather than alleviated loneliness. Findings reveal chronic illness fundamentally but not uniformly reshapes place-loneliness relationships by intersecting with existing structural conditions to create divergent spatial experiences. For participants with structural advantages, bodily vulnerabilities were buffered by stable place connections, while those with pre-existing disadvantages experienced chronic illness as compounding spatial marginalisation. Strong place attachment could coexist with spatial constraint, particularly in disadvantaged areas, challenging assumptions about the inherent benefits of place belonging. Findings underscore the need for spatially-informed interventions addressing structural inequalities (housing instability, inaccessible spaces, socioeconomic disadvantage) that determine whether chronic illness becomes a pathway to place-based connection or disconnection.

► **Exploring the links between mental health, social health, and physical environment: A prospective network analysis in a nationally representative sample**

OCHNIK, D., *et al.*

2026

Health & Place 100: 103680.

<https://doi.org/10.1016/j.healthplace.2026.103680>

The rise in mental health issues, urbanization, and loneliness presents significant societal challenges. It is imperative to comprehend the complex relationships among the various factors influencing mental health. This prospective study examines the relationships between mental, physical, and social health, as well as the physical environment, considering individual sociodemographic characteristics and objective macro-factors related to the Sustainable Development Goals, using a network approach. Moreover, the Multidimensional Mental Health Model was validated using a nationally representative sample of 1610 participants (49% women) over a three-month period. The used measurements were: Patient Health Questionnaire-9(PHQ-9), the Generalized Anxiety Disorder-7 scale(GAD-7), the Perceived Stress Scale-10(PSS-10), the Satisfaction With Life Scale(SWLS), the Neighborhood Cohesion Scale, and the Revised UCLA Loneliness Scale(R-UCLA). Physical health was assessed using the Self-Rated Health measure(SRH). The network analysis revealed that the model demon-

strated robustness and stability over time. Social health (loneliness and neighborhood cohesion) served as an indirect mechanism linking mental health to the physical environment. Moreover, urbanicity was positively associated with neighborhood belonging but negatively with social cohesion. Additionally, depression symptoms and CO2 emissions emerged as key risk factors, while forest areas and urbanicity served as influential protective factors. The centrality of neighborhood cohesion and green areas increased over time, highlighting their importance. The findings underscore the significance of a multifaceted approach to mental health that considers the interplay among social, environmental, individual, and objective macro-factors. This understanding can help develop more effective mental health prevention programs and provide valuable insights for policymakers and urban planners in creating supportive environments.

► **Beyond the care home walls: how organisational and neighbourhood environments influence community access for residents living with dementia**

PADEIRO, M., *et al.*

2026

Health & Place 100: 103710.

<https://doi.org/10.1016/j.healthplace.2026.103710>

Maintaining meaningful access to the surrounding community is increasingly recognised as a key component of well-being, quality of life, independence, identity, and social citizenship for people living with dementia. Institutions often act as gatekeepers, mediating residents' access to the surrounding neighbourhood. Yet little empirical evidence exists on how residential care facilities act as institutional mediators of residents' access to the neighbourhood beyond the institution's premises. This cross-sectional study draws on survey data from 423 directors of Portuguese care homes to examine: (i) the extent to which residents with dementia are permitted to go outside and under what conditions; (ii) how frequently they engage in individual and institution-organised outings; and (iii) the organisational and environmental determinants associated with these practices. Three logistic and one ordinal regression models were conducted, reflecting different conceptualisations of "going outside", from independent mobility to the frequency of structured outings. Overall, the findings indicate that outing opportunities are strongly shaped by organisational culture, staffing structures, staff training and awareness, facility own-

ership, and the local environment. For-profit facilities were consistently more restrictive across several models. Higher person-centred care scores, the availability of facility-owned transport and dementia-relevant staff training were associated with greater freedom or more frequent outings. Environmental perceptions also played an important role: directors who considered the surrounding area to be quiet or green tended to permit more liberal access and reported higher frequencies of outings. These results highlight the multilayered nature of community access in dementia care and underscore the need for integrated policy approaches that address organisational resources, workforce capacity and capability, and neighbourhood environments to support the independence and social participation of residents living with dementia.

► **Neighborhood disadvantage and cognitive function in older adults: The moderating role of young adult general cognitive ability**

TANG, R., *et al.*

2026

Health & Place 100: 103690.

<https://doi.org/10.1016/j.healthplace.2026.103690>

Neighborhood disadvantage in later life is associated with poorer cognition and increased vulnerability to dementia. Cognitive reserve (CR), an individual's total cognitive resources, may foster cognitive resilience against dementia in the face of neighborhood disadvantage. However, whether the neighborhood disadvantage-cognition association varies across older adults remains understudied and its moderators remain underexplored. We examined associations between late midlife neighborhood disadvantage and five domain-specific cognitive functions as well as the moderating role of young adult CR on these associations. In 1149 community-dwelling men age 61-73 living across the United States, we assessed neighborhood-level socioeconomic disadvantage using the area deprivation index and cognitive performance in executive function, episodic memory, processing speed, verbal fluency, and visual-spatial ability. General cognitive ability assessed at average age 20 was used as a measure of young adult CR. Years of education was included as another potential moderator for comparison. Greater late midlife neighborhood disadvantage was associated with poorer executive function ($\beta = -.09$, $p < .05$) and processing speed ($\beta = -.12$, $p < .05$). Moreover, those with higher young adult CR

showed a weaker association between neighborhood disadvantage and executive function ($\beta = .07$, $p < .02$). The same moderation effect was not observed for years of education. Findings are consistent with the idea that neighborhood disadvantage negatively associates with executive function, albeit less so among those with higher young adult CR. Fostering cognitive development to enhance CR earlier in life may buffer against environmental threats to later-life executive function, which is among the earliest cognitive functions affected in aging, and may, in turn, decrease vulnerability to dementia.

► **Media representations of rural and coastal cancer inequalities in the UK: A 10-year retrospective place-based analysis**

TYLER, I., *et al.*

2026

Health & Place 100: 103707.

<https://doi.org/10.1016/j.healthplace.2026.103707>

Place-based inequalities in cancer care are well documented across the UK and internationally, yet the extent to which mainstream media represents these disparities remains unclear. This study provides the first systematic, decade-long analysis of UK newspaper reporting on rural and coastal cancer issues, examining how media narratives construct and frame place-based disadvantage. Using a mixed-methods content analysis of 10,812 articles retrieved from Lexis + UK (2015–2025), 188 eligible articles were identified through structured screening. Guided by agenda-setting and framing theory and informed by place-health theory that conceptualises rural and coastal residence as structural determinants of health, data were coded for tone, key issues, cancer frames, and geographical focus, with qualitative synthesis complemented by quantitative analysis. Coverage of rural and coastal cancer was limited but increased over time. Reporting was highly localised, with national outlets offering comparatively little coverage. The most frequent narratives centred on travel burden, unequal access to treatment, workforce shortages, and the withdrawal or centralisation of services. Sociopolitical framing dominated (86% of articles), presenting cancer inequalities as structural and policy driven. Spatial imbalance was evident, with disproportionate reporting from Scotland relative to England, Northern Ireland and Wales. Personal accounts illustrated lived experience but typically reinforced broader structural narratives. Media representations of rural and coastal cancer issues there-

fore foreground systemic explanations but remain unevenly distributed across the UK media landscape. Limited national visibility may contribute to a continued policy blind spot. Strengthening place-sensitive communication and equitable media attention may support wider recognition of rural and coastal cancer challenges.

► **Neighborhood facilities and active health of older adults: An analysis across urban contexts**

WEI, Y. ET HAN, R.

2026

Applied Geography 193: 104083.

<https://doi.org/10.1016/j.apgeog.2026.104083>

Neighborhood facilities are closely related to the health status of older adults. Few studies have systematically compared, across different urban contexts, the importance of associations between built environment attributes around neighborhood facilities and older adults' active health. This study developed an integrated framework measuring active health across physical, psychological, and social domains, while incorporating urban contexts. We employed random forest and GWR models to examine the spatial variation in the importance and association of commercial, medical, and recreational facilities for the active health of older adults. Empirical results from Dalian, China, show that: (1) compared with commercial and medical facilities, more built environment attributes around recreational facilities are associated with older adults' active health; (2) the proportion of sidewalks around community centers in dense built-up contexts, the distance from shopping malls to intersections in socially marginalized contexts, and the ratio of landscape features near gymnasiums in highly modernized contexts are key variables for the active health of older adults; (3) across resource-privileged, pleasant and vibrant, and nature-accessible contexts, the density of street network around gymnasiums emerged as the most important variable for older adults' active health. This study reveals that precise intervention of neighborhood facilities must be tailored to specific urban contexts. The identified importance ranking of built environment indicators provides a basis for resource allocation under stock-oriented planning, and offers actionable insights for differentiated facility configuration and phased construction of age-friendly cities.

► **Are there differences in health state preferences between urban and rural respondents? A comparison using time trade-off and discrete choice experiment**

XIE, S., *et al.*

2026

The European Journal of Health Economics 27(4): 781-790.

<https://doi.org/10.1007/s10198-025-01860-w>

To compare health state preferences elicited using composite time trade-off (cTTO) and discrete choice experiment with duration (DCETTO) between urban and rural respondents.

Handicap

Disability

► **Estimating the magnitude and scope of disability-related direct costs: a systematised review**

BANKS, L. M., *et al.*

2026

The European Journal of Health Economics 27(5): 969-985.

<https://doi.org/10.1007/s10198-025-01851-x>

Globally, people with disabilities face a heightened risk of poverty, the extent of which is often underestimated due to a failure to account for disability-related direct costs or "extra costs". People with disabilities spend significant proportions of their income on additional goods and services (e.g. personal assistance, assistive devices, extra healthcare, transportation): paying out-of-pocket for these items can substantially lower their standard of living, while inability to meet these costs can affect their well-being and social participation. Estimating the magnitude and sources of disability-related direct costs is key for policy and planning, as it can affect determinations of poverty and also identify where additional investment may be needed to reduce the individual burden of these costs (e.g., through social protection, designing more inclusive services).

► **The longitudinal impact of childhood vision impairment on health, education, physical activity, and social outcomes: A systematic review**

RAHMATI, M., *et al.*

2026

Journal of Epidemiology and Population Health 74(3): 203371.

<https://doi.org/10.1016/j.jep.2026.203371>

Introduction This systematic review aims to investigate the broader implications of vision impairment in children, aiming to provide a more comprehensive understanding of the impact of loss, informing development of effective strategies to control preventable vision impairment through a life-course approach. Our comprehensive literature search revealed no existing systematic reviews directly addressing this review question. **Methods** We conducted a systematic search of the relevant literature using electronic databases searches including PubMed, MEDLINE (Ovid), CENTRAL, and EMBASE from inception of databases up to 20th March 2024 following PRISMA guidelines. Participants included children with vision impairment. The articles were initially screened for title and abstract, and then for full-text reports by two independent reviewers. Study quality was assessed. The outcomes were mortality, mental health, physical health, education, physical activity, and social outcomes. We synthesized and presented the results narratively to provide a comprehensive and structured interpretation of the findings. **Results** Seven articles (57,768 participants, 3–18 years) met the eligibility criteria and were included in the systematic review. Included studies were published between 2000 to 2024 with a median follow-up of 15 years. Vision impairment was linked to a heightened risk of early mortality, and adverse impacts on both physical health and mental health that included increased symptoms of anxiety or depression, and the development of various conditions including metabolic syndrome in adulthood. Vision impairment also had a negative impact on academic performance, lower physical activity, and compromised social outcomes in adolescence and adulthood. The severity of vision

impairment was associated with higher magnitude of these effects, with severe impairment having more pronounced impact. Conclusion Given the negative associations of vision impairment with various aspects of

children's lives in the long term, it is vital that the negative effects of vision impairment are understood and mitigated against as they impact beyond childhood.

► **Unravelling heterogeneity in efficiency measurements: a case study of public hospitals in Spain**

ARBELO-PÉREZ, M., *et al.*

2026

The European Journal of Health Economics 27(2): 305-318.

<https://doi.org/10.1007/s10198-025-01818-y>

Understanding efficiency in the hospital setting is now recognized as a fundamental pillar for making informed decisions and is crucial to ensuring the sustainability of health care systems. However, a significant portion of the literature assessing efficiency in the hospital sector tends to overlook heterogeneity across hospitals, leading to a notable bias in inefficiency estimation. In this paper, a stochastic frontier Bayesian model with random coefficients was used to estimate cost efficiency in the hospital sector, assuming heterogeneity across hospitals. The sample included 278 public hospitals in Spain during the period 2016–2019. The results revealed that public hospitals in Spain operate at a medium level of cost inefficiency of 12.86%, with this inefficiency being overestimated by 9.2% points if heterogeneity across hospitals is not adequately considered. This result underscores the importance of incorporating heterogeneity across hospitals in the evaluation of hospital efficiency to obtain accurate and reliable estimates.

► **Does access to quality accreditation improve health? - Patient-level evidence from German cancer care**

BRAND, T. ET BLANKART, K.

2026

The European Journal of Health Economics 27(3): 591-607.

<https://doi.org/10.1007/s10198-025-01833-z>

Despite medical advancements, the burden of cancer is increasing. Germany introduced the accreditation of local provider networks as organ cancer centers to enhance care quality. Treatment in these centers is associated with higher survival rates, prompting policymakers to advocate for further centralization. While an impact beyond treatment outcomes has been suggested, accreditation's broader effects on population health and potential spillovers across regions remain unclear. This retrospective cohort study evaluates the impact of local access to accredited cancer care on survival for eight cancer types. Using data from the German cancer registry (1999–2018), covering 5.3 million cases, and accreditation records, we identified 861,508 patients with local access to accredited care. Using nearest neighbor matching, incorporating individual and regional factors (e.g., accreditation in neighboring districts), these patients were matched with those who lacked accredited care in their vicinity. Cox proportional hazard models and G-Computation estimated hazard ratios (HR) and intention-to-treat effects for one-, three-, and five-year survival. Access to accredited centers significantly reduces mortality risk for breast, colon, and prostate cancer (HR: 0.87–0.96) and increases five-year survival probabilities for five cancer types (1.8–7.3 percentage points), with effects varying by disease severity. Access in neighboring districts improves survival rates for several cancer types, showing positive spillover effects beyond patients' home districts. These findings emphasize the role of accreditation in improving cancer care and suggest expanding such programs could enhance outcomes without imposing travel burdens on patients.

► **Measuring hospital care resilience:
a systematic literature review**

CAVALIERI, M., *et al.*

2026

**The European Journal of Health Economics 27(2):
175-211.**

<https://doi.org/10.1007/s10198-025-01807-1>

The recent Covid-19 pandemic has shown how even high-performing healthcare systems are often unprepared to cope with sudden and unforeseen surges in demand for healthcare services, drawing further attention on crucial factors ensuring their resilience in the face of extreme disruptive events. Despite extensive efforts to define health system resilience, a lack of consensus persists, making it difficult to operationalize the existing conceptual frameworks and to guide policy makers in developing adequate response strategies. Grounded on this, the present paper aims to systematically review how hospital resilience has been measured in high-income countries. Particularly, we intend to map out the different indicators and metrics used to quantitatively assess the hospitals' capacity to proactively face sudden health shocks, which can put clinical activity under pressure and at risk of disruption. Adhering to PRISMA guidelines, a systematic literature search was conducted until March 2023, by combining three databases. The review identified 1,261 studies of which 45 studies met the eligibility criteria. We found a wide range of methodological approaches that shared a narrow focus on single aspects of hospital resilience, without being able to measure it comprehensively and systematically and without accounting for its dynamic and feedback loop nature. Specifically, most of the studies looked at how to measure hospitals' capacity to absorb the shock and adapt to it, while almost neglecting their transformative capacity as well as the legacy or enduring impact of shocks.

► **De l'hôpital entreprise à l'écosystème territorial ? Enseignements d'un panorama européen sur l'évolution des hôpitaux**

MALONE, A.

2026

Sève : Les Tribunes de la Santé(86): 11-23.

Les systèmes de santé européens se caractérisent par une grande diversité institutionnelle et organisationnelle. Pourtant, depuis une quinzaine d'années, et plus encore depuis la pandémie de Covid-19, une

transformation profonde et largement convergente est engagée. Cet article analyse le passage d'un paradigme centré sur la production de soins, fondé sur la concurrence et le financement à l'activité, vers un paradigme orienté vers la production de santé, reposant sur la coopération, l'intégration et la territorialisation. Malgré une baisse importante du nombre de lits hospitaliers dans la plupart des pays d'Europe de l'Ouest, la part des dépenses hospitalières est restée stable, voire a augmenté, traduisant une recomposition plutôt qu'un déclin du rôle de l'hôpital. Les réformes visent désormais à structurer des systèmes territoriaux intégrés, articulant soins primaires, hôpital, secteur social et santé publique, autour d'instances de gouvernance communes et d'un objectif partagé : le « triple Objectif » (amélioration de la santé des populations, qualité des soins, efficience des ressources). Ces évolutions redéfinissent la place de l'hôpital, intégré à des parcours de santé territoriaux, tout en renforçant la spécialisation de certains établissements. Elles s'accompagnent toutefois d'un pilotage national accru, d'un contrôle renforcé des pratiques et de fortes contraintes budgétaires et humaines. Entre promesse de renouveau solidaire et risque de recentralisation technocratique, l'Europe de la santé se trouve à un tournant décisif.

► **La production hospitalière : comment la mesurer ?**

MILCENT, C.

2025

**Journal de Gestion et d'Economie de la Santé 3(3):
27-56.**

<https://doi.org/10.54695/jdds.043.3.0027>

Comment mesurer la production hospitalière ? Un indicateur simple est le nombre d'admissions. Toutefois, les patients qui nécessitent des soins urgents ou poly pathologiques ont des besoins de ressources différentes que les patients admis pour des procédures programmées sans comorbidités associées. Sur la période 2013-2019, nous proposons de comparer les écarts de résultats en fonction de la mesure de la production utilisée, qu'il s'agisse des coûts ou des tarifs de remboursement. Les statistiques descriptives font apparaître une segmentation du marché. Les établissements publics prennent en charge les patients avec sévérités et les soins médicaux tandis que les établissements privés se sont tournés vers des pris en charge en ambulatoire (moins de 12 heures d'hospitalisation). La comparaison des résultats de production de soins

par coûts bruts et coûts redressés permet de faire apparaître que les différences de gestion de personnel soignant impactent les différences sectorielles de production calculée par les coûts. Comparer les coûts et les tarifs remboursés met en évidence que les différences sectorielles de production est due à des différences de prise en charge des patients (ambulatoire *versus* avec nuitée) et à des différences de sévérités. Nos résultats sur la mesure de la production offrent une comparaison des différences de résultat selon les approches de mesure de la production. Introduire la dimension longitudinale permet de rendre compte des différences observées s'installant dans le temps.

► **Understanding the relationship between frequent users of emergency departments and primary care quality: A retrospective observational study in England**

MOU, L., *et al.*

2026

Health Policy 171: 105654.

<https://doi.org/10.1016/j.healthpol.2026.105654>

Background Emergency department (A&E) crowding is a growing issue in many countries, negatively affecting patient outcomes. While demand and supply constraints are known drivers, the link between primary care quality and frequent A&E use remains unclear.

Objective To explore the relationship between primary care quality and frequent A&E users in England. **Methods** We conducted a retrospective observational study using national-level secondary data covering all major A&E attendances in England in 2016/17. We applied negative binomial regression to model the association between GP practice-level counts of frequent A&E users and nine primary care quality measures: the number of admissions with ambulatory care-sensitive conditions (ACSCs) per 1,000 registered patients, clinical performance under the Quality and Outcomes Framework (QOF), and seven GP Patient Survey-based experience indicators. Additional analyses examined total A&E users and total A&E attendances. **Results** Frequent A&E users were positively associated with admission rates for ACSCs and negatively associated with patient experience (the proportion of patients recommending their GP and the ability to get same-day appointments). In additional analyses, admission rates for ACSCs were similarly associated with increased total A&E users and total A&E attendance volumes. The ability to see or speak with a preferred GP was associated with a reduction in the total volume of A&E users. **Conclusions** The findings highlight the varying aspects of primary care quality that influence frequent A&E users. Policies aiming to reduce A&E demand could focus on improving primary care quality by reducing admission rates for ACSCs and improving patient experience at GP practices.

Inégalités de santé

Health Inequalities

► **Educational gradient in physiological risk factors in a workplace: a decomposition analysis of biomarkers**

AIZAWA, T.

2026

The European Journal of Health Economics 27(4): 801-819.

<https://doi.org/10.1007/s10198-025-01822-2>

This study explores the educational inequality in a workplace in Japan in relation to the physiological risk factors. It investigates the difference in the prevalence rates of being overweight, hypertensive, dyslipidemic or diabetic between male employees who have

undergone university education and those who have not. Combining the mandatory annual health check-up data, annual stress check survey data and personnel data (total sample size=7,428), this study conducts a decomposition analysis to identify the major contributing factors to the inequality and it measures the extent to which the observed between-group disparity is associated with the differences in observable characteristics. For all four conditions, significant disparities are observed between the groups. Between-group differences pertaining to alcohol consumption, smoking behaviours, job positions, psychological stress and family structure are the major significant contributing factors behind the between-group disparities in

health. The results indicate that, along with a universal health-promoting approach, additional efforts to support less educated employees should be initiated to mitigate the health inequality.

► **Restes à charge invisibles des dépenses liées à la santé chez les personnes malades chroniques, en situation de handicap ou en perte d'autonomie : observations et implications auprès de 3 100 usagers du système de santé recrutés via un canal associatif**

AZIZA, F., *et al.*

2026

Bulletin Épidémiologique Hebdomadaire(9): 173-198.

Les restes à charge invisibles des dépenses liées à la santé (RACIDLS) désignent des dépenses de santé non remboursées, souvent absentes des dispositifs de suivi statistique, mais perçues comme nécessaires par les usagers. Cette étude visait à estimer leur montant et leur nature chez des personnes vivant avec une maladie chronique, un handicap ou une perte d'autonomie, engagées dans des réseaux associatifs.

► **Older adult service facilities and self-rated health among migrant older adults in China**

JIA, H.

2026

Health & Place 100: 103695.

<https://doi.org/10.1016/j.healthplace.2026.103695>

Background Population aging and internal migration are reshaping demographic landscapes. Migrant older adults frequently experience severed social networks. They also face institutional barriers in destination cities due to household registration restrictions. This study investigates whether universally accessible Older Adult Service Facilities (OASF) serve as a vital place-based buffering mechanism to protect the health of this uniquely vulnerable population. Methods We integrate individual-level data from the 2018 China Migrants Dynamic Survey with city-level point-of-interest data to construct a comprehensive composite OASF index. We estimate its association with the self-rated health of migrant older adults using ordered probit models, explicitly accounting for overarching city-level macroeconomic characteristics. To address

self-selection bias and potential endogeneity, we stratify the sample based on migration motives, comparing active and passive migrants. Results The OASF index shows a robust positive association with the self-rated health of migrant older adults. These health benefits are highly concentrated among socioeconomically disadvantaged subgroups of this demographic, including rural migrants, women, lower-income individuals, and those without a spouse. Crucially, the positive association is exclusive to passive migrants who relocate primarily for family obligations. This protective effect is strongest immediately after migration and exhibits a distinct time-decay pattern as the duration of residence increases. Conclusions OASF provide critical health support for migrant older adults. These physical environments effectively mitigate initial relocation stress and bridge institutional gaps. Urban policymakers should prioritize resident-based, inclusive public service provision. This approach is essential for promoting environmental health equity among aging migrant populations.

► **Health migrations: How pre-migration healthcare experiences and US healthcare challenges shape immigrants' transnational healthcare practices**

JOSEPH, T. D. ET THAPA, V.

2026

Social Science & Medicine 402: 119382.

<https://doi.org/10.1016/j.socscimed.2026.119382>

Research examining immigrants' healthcare experiences in host countries have found that various structural and socio-cultural challenges impede their healthcare access. In response, migrants address unmet medical needs by engaging in what we call "transnational healthcare practices" (THCPs). But less research has explored how migrants' pre-migration healthcare experiences influence their negotiation of care across transnational contexts. This paper aims to fill that gap by addressing four questions: 1) How do pre-migration healthcare experiences at home shape immigrants' orientation to transnational healthcare practices (THCPs)?; 2) What structural and socio-cultural healthcare challenges facilitate migrants' THCPs?; 3) What THCPs do immigrants engage in?; and 4) How do providers' views of THCPs differ from migrants' perceptions? Data comes from 132 interviews conducted with Latin American immigrants and healthcare providers in Boston from 2012 to 2019. Findings indicate that: 1) pre-migration healthcare experiences generate

"here" and "there" comparisons that facilitate migrants' THCPs in the US; 2) the complex and costly US healthcare system poses challenges that push migrants' THCP engagement; 3) migrants engage in THCPs like receiving medication from home, having transnational telehealth consultations, and traveling home for care; and 4) providers caution against THCPs because of health consequences, although migrants view them positively. Ultimately, THCPs represent migrants' agency to meet healthcare needs amid structural and socio-cultural challenges in the US healthcare system. Through highlighting the role of pre-migration healthcare practices at home as central to migrants' THCPs, this article contributes to scholarship on transnationalism, immigration, and health care.

► **Intersectionality and health inequalities among minoritized groups in Europe: A cross-sectional MAIHDA study**

LA PARRA-CASADO, D., *et al.*

2026

Social Science & Medicine 403: 119416.

<https://doi.org/10.1016/j.socscimed.2026.119416>

Health inequalities in Europe are often examined using unidimensional socioeconomic variables, which can mask heterogeneity within minoritized populations. This study applies Multilevel Analysis of Individual Heterogeneity and Discriminatory Accuracy (MAIHDA) to examine how minority group, gender, age, and education jointly pattern self-rated health among migrants and native-born ethnic minorities in 28 European Union countries. We included 22,611 participants from the European Union Minorities and Discrimination Survey (EU-MIDIS II, 2016). The sample comprised immigrants from North Africa, Sub-Saharan Africa, South Asia, Turkey, and other parts of Asia; recent migrants; and two native-born minority groups (Roma and individuals of Russian background). We analyzed 64 strata defined by minority groups, age, gender, and education, with country random intercepts. Using multilevel logistic and linear models for self-rated health, we quantified general contextual effects (VPC), specific contextual effects, and discriminatory accuracy (AUC). The results reveal a multidimensional social gradient in self-rated health. Roma and individuals of Russian background reported the poorest health outcomes, while Asian and recent migrant groups had comparatively favourable profiles. A substantial portion of the total variability in self-rated health is structured by intersectional strata, indicating that health inequity

among minoritized groups in Europe is not reducible to the independent contribution of each social dimension but reflects the convergence of ethnicity, sex, age, and socioeconomic position. These results show substantial heterogeneity within and between minoritized groups in Europe. Effective public health responses require intersectional policy frameworks that move beyond single-axis approaches to address the structural drivers of health inequity.

► **The topology of adversities: Mapping the space of adverse childhood experiences, social positions, and risk behaviors/health outcomes among US adolescents**

LU, Z.

2026

Social Science & Medicine 403: 119429.

<https://doi.org/10.1016/j.socscimed.2026.119429>

Research on adverse childhood experiences (ACEs) is dominated by a cumulative risk model demonstrating a "dose-response" relationship between the quantity of adversities and negative outcomes. This paradigm, resting on a "homogeneity assumption", obscures the heterogeneity, internal structure, and social stratification of ACEs, failing to explore which adversities and what combinations matter most. This paper introduces a relational, Bourdieusian perspective, conceptualizing ACEs as a multidimensional "space of adversity". Using multiple correspondence analysis (MCA) on data from the 2023 National Youth Risk Behavior Surveillance System (N = 13,217), I map the topology of 13 ACEs. This map is then used to situate key social positions (e.g., race/ethnicity, sexual/gender identity) and health/behavioral outcomes (e.g., substance use, suicidality) within the emergent structure. Findings reveal the "space of adversity" is structured by three orthogonal dimensions: (1) General Burden of Adversity, (2) Locus of Adversity, and (3) Internal Nature of Adversity. This structure is highly stratified: Sexual and gender minority adolescent are located within an "External Social Harm" cluster. Furthermore, specific consequences correspond to distinct regions: substance use aligns with the "Family Dysfunction" cluster, whereas suicidality aligns with the "External Social Harm" cluster. This study challenges the "homogeneity assumption" by demonstrating that not all ACEs are equivalent; their meaning is structural and relational. By visualizing the topology of adversity, this research provides a new analytical framework for trauma research and offers

crucial evidence for designing targeted interventions that address the specific adversity ecologies faced by vulnerable populations.

► **Spatial inequalities and the impact of multiple environmental risks on ethnic minority children's health: results from the Born in Bradford study**

MCEACHAN, R. R. C., *et al.*

2026

Health & Place 100: 103706.

<https://doi.org/10.1016/j.healthplace.2026.103706>

Purpose Urban environments are a key determinant of health and health inequality. We explore the impact of multiple spatial inequalities on primary healthcare use in a prospective multi-ethnic urban cohort of children. Method Primary-care consultations and prescription data for 4949 children were collected from birth to 10 years. Environmental exposure scores for air-pollution, road-traffic, green-space, and proximity to fast-food outlets were calculated longitudinally using home-addresses. The top 20% of addresses were classified as hazardous; environmental risk was calculated using the count of exposures above this threshold (range 0-4). Health impacts were assessed using negative binomial regression models adjusting for ethnicity; sex; age; birth outcomes; family financial status; area-level deprivation; maternal education and maternal health behaviours. Interaction terms were included for financial status and ethnicity. Results Half of Pakistani heritage and one-third of Other ethnic minority children experienced multiple environmental risks, compared to 7% of white British children. Rates of annual consultations and prescriptions increased for ethnic minority children as environment risks accumulated (consultations: no risks- Pakistani: 3.97 (95% CI: 3.79-4.15); Other: 3.37 (95% CI: 3.13-3.61); 4 risks- Pakistani: 4.23 (95% CI: 3.95-4.52); Other: 4.14 (95% CI: 3.55-4.72). Prescriptions (no risks- Pakistani: 6.14 (95% CI: 5.69-6.58); Other: 6.20 (95% CI: 5.53-6.87); 4 risks- Pakistani: 8.32 (95% CI: 7.41-9.22); Other: 6.54 (95% CI: 5.09-7.99). The reverse was found for white British children. Conclusions Ethnic minority children are disproportionately exposed to multiple environmental risks and are more vulnerable to their harmful effects. Improvements to multi-ethnic urban neighbourhoods may mitigate health inequalities.

► **Health selection at out- and return migration in Manitoba, Canada. A retrospective matched cohort register study**

URQUIA, M. L., *et al.*

2026

Social Science & Medicine 403: 119459.

<https://doi.org/10.1016/j.socscimed.2026.119459>

Studies on health selectivity around the time of migration that account for different sources of heterogeneity in results, such as different types of migrants, internal and external migration, and places of origin and destination, are lacking. In this population-based data linkage study in the province of Manitoba, Canada (1985-2023), we matched outmigrants and returnees with stayers within three birthplace groups of Manitoba-born (411,290), interprovincial immigrants (71,393) and international immigrants (101,192). We compared hospitalizations before outmigration and hospitalizations and mortality after return migration, stratified by the destination of leavers and the origin of returnees. During the year before outmigration, compared to those who did not migrate (stayers) Manitobans who migrated to another country had half the risk of being hospitalized (Relative Risk (RR): 0.48; 95% confidence interval (CI): 0.40-0.58) but those who migrated to another province did not. Interprovincial immigrants who returned to their province of origin had higher hospitalizations than stayers (RR: 1.21; 95% CI: 1.12-1.32) but those who remigrated did not. In the three years after return migration, returnees had lower risk of death compared to stayers in all three groups. The association was stronger for Manitobans who returned from another country (RR: 0.46; 95% CI: 0.27-0.80) than for those who returned from another province (RR: 0.83; 95% CI: 0.74-0.93). Health selectivity varies according to the birthplace of migrants and, within them, to the places of destination at outmigration and of origin at return migration. The more extreme the migration (international more extreme than interprovincial) the stronger the health selectivity.

► **When solidarity turns bad: Misappropriated and exclusive solidarity as problematic forms of solidarity in healthcare**

WEISS, E. ET PRAINSACK, B.

2026

Social Science & Medicine 403: 119417.

<https://doi.org/10.1016/j.socscimed.2026.119417>

For a long time, scholarship on solidarity has primarily focused on its prosocial dimensions. Solidarity is typically seen as a socially, ethically, or politically desirable good—something that strengthens or expresses social cohesion. More recently, however, scholars have begun to examine the troubling aspects of solidarity. In this paper, we argue that problematic, or even harmful, forms of solidarity fall into two main categories. First, exclusive solidarity, where solidarity among a group deprives those excluded from access to essential goods or rights. Second, misappropriated solidarity, where the main benefits accrue to those performing

solidarity—sometimes even at the expense of those ostensibly meant to benefit. Using two specific examples, we show how excluding migrants from public healthcare harms both the excluded and the included, weakening the broader solidaristic system. We also argue that using collective insurance contributions to fund unproven treatments, such as homoeopathy, can undermine trust and fairness. Finally, we revisit debates on linking healthcare entitlements to lifestyle choices to illustrate how exclusion and misappropriation can combine. We conclude that adopting an understanding of moral agents as shaped by their relationships to others can help prevent solidarity from becoming harmful.

Médicaments

Pharmaceuticals

► **Etendre les délais de péremption des médicaments : un enjeu économique et écologique**

REVUE PRESCRIRE
2026

Prescrire : la revue 2026(508): 142-145.

Cet article examine la question du délai de péremption des médicaments : Comment la date de péremption est-elle déterminée ? Le délai de péremption peut-il être étendu sans danger ? A-t-on des exemples récents de telles extensions ? Comment certains choix politiques peuvent-ils influencer sur l'extension de ces délais ?

► **Pharmacy cost groups for the German morbidity-based risk compensation scheme**

SCHINDLER, C. J. A., *et al.*
2026

The European Journal of Health Economics 27(1): 135-147.

<https://doi.org/10.1007/s10198-025-01809-z>

To ensure fair competition and prevent risk selection by sickness funds, Germany employs a morbidity-based risk-adjustment scheme, primarily using diagnostic data to record insured persons' morbidity. However, concerns about the manipulability and quality of

diagnostic coding have sparked discussions. This study proposes and evaluates an alternative risk-adjustment model based on pharmaceutical data, assessing its potential as an extension or an alternative to the diagnosis-based status quo.

Méthodologie – Statistique

Methodology-Statistics

► Ranking group-level outcomes with multilevel models: An information-theoretic measure of statistical separation

BASHIR, N. Z., *et al.*

2026

Social Science & Medicine 403: 119391.

<https://doi.org/10.1016/j.socscimed.2026.119391>

Social epidemiologists frequently aim to quantify how social, spatial, or organizational contexts shape individual outcomes, an aim commonly addressed through the use of multilevel models. These models readily estimate the magnitude of group-level differences, but it is more difficult to formalize the uncertainty in the relative ordering of predicted group-level outcomes, which is often considered qualitatively in practice. We propose an entropy-based coefficient, grounded in information theory, which quantifies the stability of predicted group-level rankings. This metric, termed the separation statistic (S), integrates both the magnitude of group-level differences and their statistical uncertainty, providing a principled summary of how well groups are separated in terms of their predicted outcomes. Our motivation is drawn from Multilevel Analysis of Individual Heterogeneity and Discriminatory Accuracy (MAIHDA), a widely used approach in social epidemiology for assessing group-level heterogeneity with multilevel models. We show how the separation statistic can be applied to group-level predictions derived from MAIHDA models and is compatible with both Bayesian and frequentist estimation approaches. The metric can be computed globally, across all groups, or locally, within specific subsets of interest. We demonstrate its utility using applied examples from intersectional MAIHDA and provide accompanying code to facilitate its use in future studies. By quantifying the stability of group-level predictions, the separation statistic offers a broadly applicable tool for describing certainty in the relative ordering of outcomes from multilevel models. Importantly, it should be interpreted as a descriptive measure of ranking uncertainty rather than a prescriptive target, with its limitations carefully considered in applied settings.

► Development of an Individual Healthcare Provider Database

CHORNIY, A., *et al.*

2026

Med Care Res Rev 83(4): 282-292.

<https://doi.org/10.1177/10775587261424553>

The project described in this article develops a comprehensive, public database of U.S. individual healthcare providers from 1999 to 2025 («Provider Database»). We combine data from multiple sources: NPES (National Plan and Provider Enumeration System), ResDAC Unique Physician Identification Number Directory (UPIN Directory), Medicare Carrier files; PECOS (Medicare Provider Enrollment, Chain, and Ownership System), MD-PPAS (Medicare Data on Provider Practice and Specialty), DEA (Drug Enforcement Administration), and physician vertical integration data. The database covers 7 million providers, including 1.36 million physicians, covers the 2007 switch from UPIN to National Provider Identifier (NPI), and includes 918,609 NPI-UPIN pairs. Side public databases track providers' zip code and physician integration status over time. Side non-public databases (available to researchers with Carrier file access) include providers' Medicare provider identification number and tax identification number. This article details the database methodology and illustrates its use in studying trends in provider supply, over time and across states, and physician integration.

► Difference-in-Differences Estimators of Intertemporal Treatment Effects

DE CHAISEMARTIN, C. ET D'HAULTFŒUILLE, X.

2026

The Review of Economics and Statistics 108(4): 863-880.

https://doi.org/10.1162/rest_a_01414

We study treatment-effect estimation using panel data. The treatment may be nonbinary, nonabsorbing, and the outcome may be affected by treatment lags. We make a parallel-trends assumption and propose event-study estimators of the effect of being exposed to a weakly higher treatment dose for ℓ periods. We also propose normalized estimators that estimate a weighted average of the effects of the current treat-

ment and its lags. We also analyze commonly used two-way fixed-effects regressions. Unlike our estimators, they can be biased in the presence of heterogeneous treatment effects. A local-projection version of those regressions is biased even with homogeneous effects.

► **L'évaluation ex ante et ex post des politiques sociales : est-on dans une impasse ?**

ELBAUM, M.

2026

Revue de l'OFCE(192): 100-129.

L'expérience française en matière d'évaluation des politiques sociales connaît actuellement des limites majeures. Un état des lieux des pratiques d'évaluation et de la façon elles sont mobilisées au service de l'action publique, au confluent du monde de la recherche et des administrations, permet de les mettre en évidence. En premier lieu, les politiques sociales sont fortement dépendantes d'incertitudes macroéconomiques de nature plurielle qui tendent à compliquer la cohérence entre prévisions à court terme, et moyen et long termes. Elles rendraient nécessaire un débat transparent et élargi autour de leurs hypothèses, qui, en dépit du développement des instruments de prévision et de microsimulation et de l'existence d'instances comme les Hauts Conseils, est actuellement insuffisant.

► **Vous avez dit auto-administré ? Réflexions sur le travail d'accompagnement des répondant-es lors d'une enquête en ligne**

HÉNAUT, L., *et al.*

2026

Genèses 142(1): 159-178.

<https://doi.org/10.3917/gen.142.0159>

Proposant un retour sur une enquête en ligne conduite auprès de cadres du secteur médico-social (n = 371), cet article montre comment diminuer le taux de non-réponse et les biais d'autosélection propres à ce mode de passation des questionnaires grâce à un accompagnement asynchrone et personnalisé proposé aux répondant-es via des outils numériques et téléphoniques. Il analyse les bénéfices et les limites économiques, méthodologiques et éthiques des stratégies de suivi et de relance.

► **Quantile Effects in Discrete Choice with Social Interactions**

LIN, Z.

2026

The Review of Economics and Statistics 108(4): 1098-1108.

https://doi.org/10.1162/rest_a_01459

This paper provides a method to study quantile effects in discrete choice with social interactions. The method is based on a behavioral social interactions model from quantile preference in decision making and demonstrates peer effects on different quantiles of discrete outcomes. The peer effects parameters are estimated by a nested pseudoscore (NPS) approach, which is developed to tackle the computational burden pertaining to the social interactions model. Consistency and asymptotic normality are established for the proposed NPS estimator. We illustrate the finite sample performance of the model and the estimator by Monte Carlo experiments and an application of peer effects among students on exercise decisions, using the National Longitudinal Study of Adolescent Health dataset.

► **Ten Recommendations for Modelling Cost Effectiveness of Screening: Perspectives of an International Stakeholder Group**

MANDRIK, O., *et al.*

2026

PharmacoEconomics 44(7): 799-814.

<https://doi.org/10.1007/s40273-026-01602-7>

Modelling the cost effectiveness of screening interventions presents unique challenges. These relate to a lack of knowledge about underlying health states and disease progression in the absence of screening, added costs arising from incidental findings, screening recall and follow-up diagnostics, imperfect uptake, potential harms to otherwise healthy people, and impacts on resource capacity and equity. No specific but generalisable advice currently exists to help guide health economic modellers working in this area. There is a need for tailored recommendations beyond the widely used, health economic modelling frameworks. We aimed to develop a set of recommendations for modelling the cost effectiveness of screening programmes. In our iterative process, we first drafted a conceptual document outlining key issues requiring recommendations. This framework was then expanded based on additional themes identified through a survey of screening modelling experts. Next, the draft recommendations were

shared with a broader international expert group, which included modellers, health economists and policy specialists. Finally, the core concepts were refined and agreed upon during a virtual stakeholder meeting. A set of ten recommendations and a checklist are presented. The document provides guidance on critical methodological requirements for modelling screening interventions. These guidelines are intended to help health economic modellers and screening policy makers working to evaluate screening interventions across a wide range of diseases and jurisdictions with clarity, rigour and consistency.

► **Estimating System-Wide Healthcare Costs Using a Health System Model: Application to the Thanzi La Onse Model of Malawi**

MOHAN, S., *et al.*

2026

Applied Health Economics and Health Policy 24(4): 707-725.

<https://doi.org/10.1007/s40258-026-01030-w>

Modelling approaches that consider system-wide delivery platforms rather than single diseases can be instru-

mental in economic evaluation and forward-looking policy formulation. This study develops a costing approach tailored to the Thanzi La Onse (TLO) model of Malawi's healthcare system, with general applicability to other health system models.

► **Valuing health and wellbeing using discrete choice experiment: exploring feasibility, design effect and international preference similarity**

WANG, H., *et al.*

2026

The European Journal of Health Economics 27(2): 339-353.

<https://doi.org/10.1007/s10198-025-01821-3>

Discrete choice experiments (DCEs) are increasingly used in health preference elicitation studies. However, few studies have explored applying a DCE to value long health and wellbeing measures. This study evaluates feasibility, examines the impact of attribute ordering and explores if similar preference exists between countries.

Politique de santé

Health Policy

► **Les institutions de la santé**

TABUTEAU, D., *et al.* 2026

Sève : Les Tribunes de la Santé 87(1)

Ce numéro est consacré aux institutions et agences dans le domaine de la santé en France. Après des tentatives anciennes peu concluantes, notamment au début du XX^e siècle, les crises sanitaires récentes et les enjeux de maîtrise des dépenses ont favorisé la création de nombreuses structures d'expertise et de gestion. A travers différents articles, ce numéro propose de mieux comprendre ces institutions, anciennes ou récentes, en présentant plusieurs acteurs clés qui participent à l'évolution du système de santé et aux politiques sanitaires.

► **The impossibility problem: When public health policies require what structural conditions prevent**

ALBERT, K., *et al.*

2026

Social Science & Medicine 402: 119353.

<https://doi.org/10.1016/j.socscimed.2026.119353>

"Bubbles" were introduced as a nonpharmacological strategy in 2020 COVID-19 public health guidelines, comparable to social distancing measures. Despite the seemingly clear metaphor of bubbles, public communication and guidelines for bubbling across Canada and globally created a context of ambiguity, confusion, and inconsistency. It was up to individual citizens, households, groups, schools, and workplaces to know what a bubble was and how to implement bubbling practices. In spite of its widespread adoption as a pandemic

intervention, little is known about how the public made sense of this guideline and how they attempted to follow this guideline in practice. Drawing on data from 39 semi-structured qualitative interviews with people in British Columbia Canada, between October and December 2020, this research study explains how people understood and responded to the idea of bubbles. Our findings reveal the role of situated trust and compensatory strategies in shaping bubbling practices in the context of multiple unknowns, as well as the disconnect between how people understood bubbles conceptually versus how they enacted them.

► Faut-il supprimer les ARS ?

BASSET, B. ET BOURDILLON, F.
2026

Sève : Les Tribunes de la Santé 86 : 89-91.

Notre système de santé va mal. Devant les difficultés de tous ordres qu'il rencontre les responsables politiques n'évoquent qu'un seul responsable : les agences régionales de santé (ARS), et ne proposent qu'une seule solution, une réforme institutionnelle. Ce court texte écrit sous forme de tribune, propose un rapide rappel historique des motifs de création des ARS, les acquis indéniables à leur actif sans passer sous silence les imperfections d'une nouvelle administration. Faut-il pour autant supprimer les ARS ? La santé publique a besoin d'une cohérence d'ensemble que la loi a confiée aux ARS, ainsi que d'une action dans la durée qui ne doit pas être remise en cause.

► Precision medicine "versus" or "for" public health? Different configurations of precision medicine in relation to the social determinants of health

GALASSO, I., *et al.*
2026

Social Science & Medicine 402: 118785.

<https://doi.org/10.1016/j.socscimed.2025.118785>

The relationship between precision medicine (PM) and public health (PH) is far from straightforward. On the one hand, some scientific experts envision PM as helping to advance PH interventions and the health of populations. This is argued to be realisable through a framework that they term 'precision public health' (PPH). On the other hand, a range of PH and other scholars question whether PM is a "distraction" from population-wide health urgencies; in particular, ine-

qualities relating to the social determinants of health (SDH). Consequently, individualized PM is framed as coming at the expense of the population. This paper examines these two poles and other positions in-between, and vis-à-vis major national PM initiatives, to investigate how PM is configured in relation to the SDH. Specifically, we analysed documents relevant to, and conducted qualitative interviews in the context of, the USA Precision Medicine Initiative (PMI) and the UK 100,000 Genomes Project (100KGP). Through these data, we characterise three principal configurations of PM that enact particular relationships with PH that have varying implications for health and societies. We conclude by re-examining the potential contributions of PM to generating knowledge and policy in relation to the SDH, and by calling for PM to more reflexively intervene within the health of populations through - and with - the sociopolitical domain.

► US State Policy Index for Population Health Analyses

MONTEZ, J. K., *et al.*
2026

The Milbank Quarterly 104(2): 420-448.

<https://doi.org/10.1111/1468-0009.70085>

Policy Points Changes in states? policy contexts since the 1980s may help explain why mortality rates among working-age adults have risen and become more unequal across geographic areas. Investigating this pressing issue requires a new, industry-standard measure of those contexts. During 1980-2023, higher scores on the State Policies and Politics Database (SPPD) State Policy Index (reflecting an adoption of policies that strengthen economic security, expand safety nets, and discourage risky behaviors) were strongly associated with lower working-age mortality rates. The SPPD State Policy Index is a valid, transparent, replicable, and easily updated measure that is useful for understanding how the general orientation of state policies predicts mortality. Context Recent studies have linked the rising rates and growing disparities in working-age mortality partly to changes in US states? policy contexts since the 1980s. Yet, such studies largely rely on measures of states? policy contexts, or? policy indices? that were created for other purposes, are not regularly updated, and use complex methods that can be difficult to interpret and replicate. Further elucidating the mortality trends and disparities would benefit from a policy index that is designed for population health analyses and a clearer understanding of the utility of such indices.

Methods Drawing on the World Health Organization's Social Determinants of Health Framework and existing studies of the impact of specific state policies, we identified 11 policies to be included in an annual index from 1980-2023. It ranges from 0 to 1 on a conservative-to-liberal continuum. We evaluated the index on multiple dimensions of validity. Findings The index demonstrates strong validity. Exhibiting convergent validity, the index has a 0.89 correlation with two existing validated and widely used holistic policy indices created for other purposes using more than 135 state policies and two different modeling approaches. Exhibiting predictive validity, the index is strongly associated with all-cause and cause-specific working-age (ages 25-64) mortality rates. The strength of the associations is similar to those using the two existing indices but have standard errors of about one-third to one-half the size. The index is also associated with mortality at younger and older ages. Conclusions The State Policies and Politics Database (SPPD) State Policy Index is valid for investigating the links between the general orientation of states' policies and mortality rates. It provides researchers with a straightforward, transparent, annual, and timely index. We discuss the reasons for using policy indices, particularly in an era of policy

co-occurrence, and address two criticisms of indices.

► **La protection publique de la santé de l'enfant**

VERON, P.

2026

Revue de droit sanitaire et social 2026(2): 269-279.

Pilier incontournable de la protection de la santé de l'enfant ou de l'adolescent, l'intervention des pouvoirs publics apparaît protéiforme et entretient des relations complexes avec la protection de « première ligne » qui incombe aux titulaires de l'autorité parentale. L'autorité publique intervient parfois pour imposer aux parents des obligations relatives à la santé du mineur, tandis qu'elle leur confie le plus souvent le soin d'activer les droits sociaux dont ce dernier est bénéficiaire. La protection est parfois assurée par la collectivité publique de manière plus directe encore lorsqu'elle permet la prise en charge des mineurs sans ou même contre la volonté parentale, ou indépendamment de celle-ci dans le cadre de politiques de santé publique (résumé de l'éditeur).

Prévention

Prevention

► **Littérature en santé et approche One Health : l'exemple des zoonoses chez les étudiants français en santé**

DELEBARRE, F. ET MASSON, J.

2026

Santé Publique 38(2): 77-89.

<https://doi.org/10.3917/spub.262.0077>

Introduction : Les zoonoses constituent un enjeu de santé publique et soulignent l'importance de l'approche *One Health*. Leur prévention repose sur la littérature en santé, en particulier chez les futurs professionnels de santé qui auront un rôle clé dans la promotion de la santé. L'objectif de cette étude est d'évaluer et de comparer les connaissances perçues des étudiants français en santé concernant l'approche *One Health* et les zoonoses, avec d'autres filières d'études. Méthode : Pour cela, une étude transversale analytique

fut menée auprès d'étudiants de l'enseignement supérieur en France (n = 960). À travers un questionnaire auto-administré construit à partir de l'échelle CCiC, l'étude explore trois dimensions : les connaissances anthropocentrées, les connaissances environnementales responsables et les connaissances de santé environnementale responsables. Résultats : Grâce aux tests statistiques non paramétriques, les résultats permettent d'affirmer que les étudiants en santé déclarent une meilleure compréhension des enjeux sanitaires liés aux zoonoses que les autres étudiants. Cependant, aucune différence notable n'a été observée concernant les dimensions environnementales et de santé environnementale. Pour l'ensemble des étudiants, les connaissances de santé environnementale sont les plus élevées, suivies des connaissances environnementales, puis des connaissances anthropocentrées. Discussion : Ces résultats suggèrent que la formation en santé favo-

rise principalement une approche centrée sur le risque sanitaire des zoonoses, sans pour autant renforcer une vision intégrée de l'approche *One Health* vis-à-vis du risque qu'elles représentent pour la santé humaine. Cela souligne l'intérêt de renforcer l'intégration de l'approche *One Health* dans la formation des futurs professionnels de santé.

► **Mobiliser les populations migrantes ou précaires pour des approches collectives de promotion de la santé**

HERMET, L., *et al.*

2026

Santé Publique 38(2): 119-128.

<https://doi.org/10.3917/spub.262.0119>

Introduction : L'accès aux soins des populations migrantes et précaires reste marqué par de fortes inégalités. Les approches collectives de santé, entendues comme des interventions réunissant plusieurs personnes autour de problématiques de santé partagées (ateliers d'information, échanges collectifs, actions de prévention ou de promotion de la santé), sont reconnues comme un levier de promotion de la santé, mais leur mise en œuvre auprès de ces publics demeure complexe. L'objectif de cette étude était d'explorer les représentations de la santé de patients migrants fréquentant un centre de Médecins du Monde et d'identifier les freins et leviers à leur mobilisation dans des activités collectives. Méthode : Une étude qualitative exploratoire a été menée au sein du Centre d'accueil de soins et d'orientation (CASO) de Médecins du Monde à Nice. Vingt-et-un entretiens exploratoires et huit entretiens semi-directifs ont été réalisés auprès de patients migrants francophones, jusqu'à saturation des données. Les entretiens ont été enregistrés, retranscrits et analysés par approche thématique. Un double codage partiel a été effectué avec le logiciel NVivo. Résultats : Les participants présentaient des représentations contrastées de la santé, allant d'une priorité absolue à une préoccupation secondaire derrière le logement, le travail ou la régularisation administrative. Le médecin était perçu positivement, comme une figure centrale de soins et de protection. L'intérêt pour les activités collectives variait : certains y voyaient une opportunité de partage, d'autres exprimaient une réticence. Plusieurs freins étaient identifiés : barrière linguistique, contraintes liées au travail informel, fatigue, tensions communautaires et absence de médiateurs culturels. Discussion : La mobilisation des patients migrants dans des approches collectives

de santé nécessite des conditions spécifiques : inscription dans la durée, co-construction avec les patients, implication de pairs et prise en compte de leurs priorités de vie. Cette étude exploratoire permet d'identifier les conditions de faisabilité et constitue un socle pour la conception d'actions pilotes, dont l'évaluation et la définition d'indicateurs d'impact seront abordées ultérieurement. Conclusion : Les approches collectives de santé peuvent constituer un levier pertinent pour réduire les inégalités d'accès aux soins, à condition d'être adaptées aux contraintes sociales et aux priorités de vie des populations migrantes et précaires.

► **Factors related to participation in colorectal cancer screening in a Southern European region: a prevalence survey**

MARTÍN-GARCÍA, P., *et al.*

2026

European Journal of Public Health 36(3).

<https://doi.org/10.1093/eurpub/ckag060>

The colorectal cancer screening programme was fully implemented in the Community of Madrid in 2019. This study aimed to analyse factors related to participation during the subsequent 4 years. We conducted a cross-sectional study using data from the Community of Madrid's Noncommunicable Disease Risk-Factor Surveillance System (SIVFRENT) (2020–23). Study population included individuals aged 50–69 years. We analysed the association between faecal occult blood test (FOBT) performance and demographic, socioeconomic, and lifestyle variables. Crude and adjusted prevalence ratios (aPR) were calculated using Poisson regression models, stratified by sex. Among 3813 participants, 52.1% were women. Overall, 55.3% (95% CI: 53.6–57.0) underwent an FOBT for screening purposes, with a greater proportion of men (57.8%) than women (53.1%) ($P < .05$). The highest participation occurred during 2023. Among men, being separated or divorced (aPR: 0.80; 95% CI: 0.67–0.94) and being aged 50–59 years old (aPR: 0.92; 95% CI: 0.85–0.99) were associated with a lower likelihood of undergoing an FOBT. Among women, lower participation was associated with being underweight (aPR: 0.63; 95% CI: 0.40–0.97), widowed (aPR: 0.78; 95% CI: 0.66–0.93), born outside Spain (aPR: 0.82; 95% CI: 0.72–0.95), a current smoker (aPR: 0.84; 95% CI: 0.75–0.95), and being under 60 years of age (aPR: 0.86; 95% CI: 0.79–0.94). Overall, a gradual improvement in colorectal cancer screening participation was observed, with men participating at

higher rates than women. The associated factors differ between men and women and need to be accounted for when strategies to increase programme coverage are implemented.

► **Social capital and vaccine decision-making: A scoping review**

MONETTE, E. ET DUVAL, G.

2026

Social Science & Medicine 403: 119443.

<https://doi.org/10.1016/j.socscimed.2026.119443>

The term social capital has been widely used in social science to explain how relationships, norms, and shared resources shape opportunities within communities. This concept has gained recent prominence in public health research as scholars seek to understand the social dynamics underlying vaccine decision-making and hesitancy. Guided by major theoretical perspectives of Bourdieu, Coleman, and Putnam, this paper examines how social capital has been applied to the study of vaccine uptake and synthesizes research findings about its influence on vaccination behaviours. Sources (n = 581) were gathered from the databases Medline, Embase, CINAHL, and Web of Science and uploaded to Covidence. Following removal of duplicates (n = 124), the titles and abstracts of 457 sources were screened for inclusion of the search concepts “vaccination” and “social capital”. Full texts of 67 sources were screened for relevant use of search concepts (i.e., study focus on vaccination behaviours and use of “social capital” as an underpinning theory), resulting in 34 articles for final inclusion. Studies were coded for their theoretical grounding, methodology, and the specific forms of capital examined. Findings indicate that social capital shapes vaccine decision-making in complex and context-dependent ways. While higher levels of trust, cohesion, or civic participation are often associated with vaccine uptake, strong bonding ties and community-embedded norms sometimes facilitate the spread of misinformation and reinforce hesitancy. Overall, the review demonstrates that social capital can function as both a facilitator and barrier to vaccination, underscoring the importance of local context and the need for nuanced, theory-informed approaches to understanding vaccine behaviours.

► **L’empowerment en santé communautaire : perspectives théoriques et implications pour la promotion du vieillissement en santé**

MONTAIGNE, É.

2026

Santé Publique 38(2): 129-139.

<https://doi.org/10.3917/spub.262.0129>

Introduction : L’empowerment est un concept central en santé publique, mobilisé pour réduire les inégalités sociales de santé. Ses multiples conceptualisations reflètent toutefois des perspectives théoriques variées, soulevant des tensions épistémologiques et des enjeux pratiques. Objectif : Cette revue narrative critique de la littérature vise à analyser les principales perspectives théoriques de l’empowerment et à identifier des approches pertinentes pour promouvoir le vieillissement en santé ancrées dans la santé communautaire. Méthodologie : Une recherche ciblée a été menée dans les bases de données PubMed, CAIRN et Google Scholar, à l’aide de mots-clés anglais et français (« empowerment », « santé communautaire », « promotion de la santé », « vieillissement en santé »). Les publications incluses proposaient des analyses conceptuelles, critiques ou interdisciplinaires pertinentes pour la santé communautaire et la promotion du vieillissement en santé. Afin d’élargir la portée de l’analyse, les références bibliographiques des publications retenues ont également été examinées. Une analyse thématique itérative a permis d’identifier des tendances conceptuelles et des implications pratiques. Résultats : L’analyse soutient la pertinence d’une approche multiscale de l’empowerment, prenant en compte les dimensions individuelle, communautaire et organisationnelle, telle que proposée par Ninacs. Cette approche peut renforcer l’impact des interventions sur les inégalités sociales de santé. La promotion du vieillissement en santé illustre concrètement cette dynamique : l’empowerment des personnes âgées transforme les rapports de pouvoir, redéfinit les rôles professionnels et favorise l’émergence de collaborations plus équitables et solidaires. Conclusions : l’empowerment constitue un levier conceptuel et pratique pour conjuguer santé communautaire et promotion de la santé. En assumant sa portée idéologique et en s’appuyant sur des approches théoriques adaptées, il contribue à concevoir des interventions plus justes, inclusives et porteuses de sens pour les populations concernées.

► **Health prevention research in France: Increasing investment is a priority, rethinking targets is equally crucial**

POTVIN, L., *et al.*

2026

Canadian Journal of Public Health 117(1): 5-9.

<https://doi.org/10.17269/s41997-026-01164-3>

► **The interplay between social connection and compliance with COVID-19 preventive measures**

VERHAEGEN, K. A., *et al.*

2026

European Journal of Public Health 36(3): ckag023.

<https://doi.org/10.1093/eurpub/ckag023>

The COVID-19 pandemic required substantive preventive measures to stop the spread of the SARS-CoV-2 virus. As the effectiveness of these measures highly depended on public adherence, understanding the determinants of compliance with preventive measures is crucial. While some influencing factors have been identified already, the role of social connection is not fully understood. Interestingly, social connection might be reciprocally affected by compliance with preventive measures in a way that poses a trade-off between

social connection and compliance. Therefore, the aim of the current study was to evaluate the bidirectional relationship between social connection and compliance with preventive measures. This was done using longitudinal data from six waves (April 2020–March 2021) of the Belgian online COVID-19 Health Surveys, of a cohort of 11 974 adults. Random-intercept cross-lagged panel modelling was used to test whether social connection positively predicted subsequent compliance, and whether compliance negatively predicted subsequent social connection. Social support and social satisfaction served as social connection indicators. Compliance was modelled per separate preventive measure. The results showed that social support and social satisfaction were positively associated with subsequent compliance with several measures. Some effects were particularly pronounced in the most stringent waves. In the other direction, compliance with social restriction negatively predicted subsequent social satisfaction. Through its relation with compliance, social connection can be relevant for tackling public health crises that require public response. Vice versa, our results stress social connection as an area of concern in such crises. Thus, sustainably fostering social connection could benefit future pandemic preparedness.

Psychiatrie

Psychiatry

► **General practitioners' choices when starting treatment for major depression: Update of Dusmenil et al. survey (2012) in view of new mental health devices**

ARDERIU, S., *et al.*

2026

L'Encéphale 52(4): 343-352.

<https://doi.org/10.1016/j.encep.2025.10.003>

Résumé Introduction et objectifs En 2011, une enquête du Ministère de la Santé a évalué les choix des médecins généralistes (MG) lors de l'instauration d'un traitement pour un épisode dépressif caractérisé (EDC). Cette étude a montré les limitations de la prise en charge des EDC en soins primaires, en particulier dans les épisodes légers, reposant essentiellement sur la pharmacothé-

rapie. Depuis, des dispositifs de santé mentale ont été mis en place en France. Mon Soutien Psy permet d'accéder jusqu'à 12 consultations prises en charge avec un psychologue (8 consultations lorsque l'étude a été réalisée). Le dispositif de soins partagés en psychiatrie (DSPP) est un programme spécifique mis en œuvre dans la région Occitanie, dans le but d'améliorer la collaboration entre psychiatres et médecins généralistes au niveau local. L'objectif de cette étude est de réaliser à nouveau cette enquête afin d'évaluer l'évolution de la prise en charge de la dépression au vu de ces nouveaux dispositifs. **Méthodes** L'enquête et les vignettes de cas de l'étude de 2011 ont été utilisées, ainsi que des items supplémentaires sur les nouveaux dispositifs. Cette étude a été réalisée au moyen d'un questionnaire électronique envoyé aux médecins généralistes par

l'Union régionale des professionnels de santé (URPS) de 3 départements français (Bouches-du-Rhône et Ille-et-Vilaine, avec « Mon Soutien Psy » et Haute-Garonne pour la DSPP). Résultats Au total, 158 médecins généralistes ont répondu à l'enquête – 69,0 % de Haute-Garonne – pour un taux de réponse total de 3,4 %. En comparaison avec l'enquête de 2011, on constate une augmentation significative du nombre de médecins généralistes prenant en charge leurs patients en collaboration avec un spécialiste (6,3 versus 3,3 % ; $p < 0,05$) et évaluant la situation avant de prescrire un antidépresseur (44,2 versus 10,7 % ; $p < 0,00001$). Ces médecins généralistes étaient majoritairement originaires de la Haute-Garonne (avec accès DSPP). Les opinions sur les psychothérapies se sont améliorées par rapport à l'étude de 2011, mais des idées préconçues demeurent. Les freins n'étaient plus le remboursement ou la réticence du patient à suivre une psychothérapie mais plutôt les délais trop longs pour obtenir un rendez-vous. La prise en charge des EDC en soins primaires était globalement plus conforme aux recommandations. Conclusion Cette étude suggère des résultats encourageants: les pratiques des médecins généralistes sont plus conformes aux recommandations de prise en charge et ils sont plus enclins à gérer eux-mêmes les cas tout en prenant conseil auprès de spécialistes, même s'il reste des pistes de progression. Cependant ces résultats nécessiteraient d'être confirmés par des études sur un échantillon plus large. Les nouveaux dispositifs de santé mentale semblent être l'une des raisons de ces améliorations.

► **Decision of compulsory psychiatric hospitalization in patients referred to emergency departments for a first forensic expertise: Impact of the pre-existing care network**

BIKRANI, O., *et al.*

2026

L'Encéphale 52(3): 228-235.

<https://doi.org/10.1016/j.encep.2025.08.004>

Introduction The recourse to compulsory psychiatric hospitalizations is authorized in Belgium in case of the presence of strict legal criteria defined by the law on the protection of patients with mental illness. In recent years, the number of compulsory psychiatric hospitalizations has been constantly increasing, leading to an increasing saturation of specialized hospitalization units. To better understand this problem, the aim of this study was therefore to investigate the impact of a

medical contact during the three months preceding the occurrence of a first forensic expertise on the decision to involuntarily hospitalize psychiatric patients referred to emergency departments. **Material and method** Three hundred and ninety-nine patients were retrospectively extracted from the database of forensic expertise performed in emergency departments between January 2021 and December 2023. The impact of a medical contact during the three months preceding the occurrence of a first forensic expertise on the risk of compulsory psychiatric hospitalization was assessed using logistic regression analyses. **Results** Sixty-two percent of forensic expertise resulted in compulsory psychiatric hospitalization. In addition, a medical contact during the prior three months was associated with higher risk of compulsory psychiatric hospitalization in patients referred to emergency departments for a first forensic expertise. **Conclusion** In this study the results seem to confirm the hypothesis of an exhaustion of therapeutic alternatives available to compulsory care in some psychiatric patients involuntarily hospitalized after a first forensic expertise. This underlines the importance of developing new care networks that are more accessible to these patients and better adapted to their needs.

► **Is higher-quality secondary mental healthcare more costly? A systematic review**

CHEN, J., *et al.*

2026

Health Policy 172: 105695.

<https://doi.org/10.1016/j.healthpol.2026.105695>

Background Mental health disorders impose a substantial disease and economic burden to global health systems. Although expenditure on mental healthcare comprises a relatively small part of overall healthcare budgets, it tends to be concentrated in the secondary mental healthcare sector. This review examines whether higher-quality secondary mental healthcare is associated with increased costs, and explores the processes underlying this relationship. **Method** A two-phase structural search strategy was applied. The initial search was conducted in MEDLINE, Embase, PsycINFO, and EconLit in September 2023, following a supplementary search using PubMed citation tracking and Similar Articles functions in March 2026. Risk of bias was assessed using the ROBINS-I for intervention studies and the ROBINS-E for exposure studies. The review followed PRISMA 2020 guidelines. **Results** Nine studies were included, all rated to be at moderate to very high

risk of bias. The overall evidence suggests that higher quality care does not necessarily entail higher costs. Interventions and care models emphasising timely access, continued outpatient service delivery were associated with improved quality indicators and stable or reduced costs. Confounding was the dominant source of bias across all studies. Conclusion Higher-quality secondary mental healthcare may be achievable without increased expenditure, potentially through investment in timely accessible and continued care models. However, the evidence base remains limited and largely observational. Strengthening linked administrative data infrastructure and applying robust causal methods will be essential to inform policy design and service delivery.

► **Clinical and sociodemographic characteristics of patients with heart failure and schizophrenia or psychotic disorder in France**

DALFIN, W., *et al.*

2026

L'Encéphale 52(4): 353-357.

<https://doi.org/10.1016/j.encep.2025.10.004>

Objectives To assess the clinical and socio-demographic characteristics of patients hospitalized for heart failure (HF) with schizophrenia or psychotic disorder comorbidity. **Method** We conducted an observational study from the national French PMSI database. We included patients hospitalized with a principal diagnosis of HF between 2019 and 2023, with and without a secondary diagnosis of schizophrenia or psychotic disorder. In total, we included 693,398 HF patients, 7368 with and 686,030 without schizophrenia or psychotic disorder. **Results** Men with HF and schizophrenia or psychotic disorder were on average eight years younger (69.9 vs. 77.8 years), and women were four years younger (79.4 vs. 83.6 years) than men and women without this comorbidity. Overall, HF patients with schizophrenia or psychotic disorder were more often women (57.9 vs. 49.9%) and had a higher prevalence of obesity (29.9 vs. 22.6%), chronic obstructive pulmonary disease (19.6 vs. 14.2%), and stroke (12.6 vs. 10%). The length of stay was longer in patients with schizophrenia (11.7 vs. 10.2 days). Men with HF and schizophrenia or psychotic disorder were on average ten years younger than women with this pathology (69.9 vs. 79.4 years) and had a higher prevalence of myocardial infarction (13.7 vs. 8.3%). **Conclusion** Patients with HF and schizophrenia or psychotic disorder are younger than HF

patients without this comorbidity. Despite the younger age, patients with schizophrenia or psychotic disorder have a higher burden of comorbidities and a longer length of stay. Patients with schizophrenia or psychotic disorder, especially men, need close follow-up to prevent the early occurrence of HF.

► **Mapping European mental health policies: a scoping review and policy recommendations**

DRAKOS, K., *et al.*

2026

Health Policy 172: 105698.

<https://doi.org/10.1016/j.healthpol.2026.105698>

Background The rising burden of mental health problems requires effective, comprehensive, and evidence-informed policymaking. Despite their importance, mental health policies often remain poorly implemented. **Objective** This review aimed to map European mental health policies, identify patterns in the types of policy instruments used (e.g., legislation, guidelines, funding mechanisms, initiatives), assess which stages of the policy cycle are most addressed, and examine the role of stakeholders in shaping policy effectiveness. **Methods** This scoping review narratively synthesised data from peer-reviewed research and transnational policy documents on mental health interventions across health, education, employment, and social equity. Policy recommendations were derived from identified gaps and best practices. **Results** Of 3084 articles retrieved from databases and 197 documents from grey literature, we obtained 102 reports of 101 studies. These were released from 2009 to 2025, with gradual increase in the last ten years. The main themes covered were healthy workplace (17.8%), mental health services (15.8%), and child and adolescent health (10.9%). Our synthesis also highlights the types of instruments employed: guidelines and recommendations (54.5%), initiatives (21.8%), legislation (17.8%), and funding mechanisms (5.9%). Stakeholder engagement was accounted for in 46.6% of studies, with multi-level participation strongest in community-based initiatives and weakest in legislative processes. Additionally, many studies reported policies in evaluation (54.5%), formulation (42.6%), or implementation phase (19.8%), with smaller contributions to agenda setting (4.0%). **Conclusions** Aligning policies with evidence-based recommendations, strategically selecting policy instruments, addressing policy cycle gaps, and enhancing stakeholder engagement can improve implementa-

tion and outcomes of mental health policies in the European region.

► **US State Policy Contexts and Mental Health Among Working-Age Adults**

GUTIN, I., *et al.*

2026

The Milbank Quarterly 104(2): 449-487.

<https://doi.org/10.1111/1468-0009.70077>

Policy Points States' overarching policy contexts are a meaningful yet overlooked predictor of adults' mental health, with more conservative contexts associated with worse mental health outcomes over a 30-year period. Counterfactual analyses suggest that widespread policy shifts could meaningfully alter the national prevalence of mental distress, positioning state policy contexts as important yet underutilized levers for improving population mental health. These associations are strongest among adults without a college degree, underscoring that state policy contexts may exacerbate existing educational disparities in mental health. CONTEXT: Mental health among US working-age adults notably worsened during the COVID-19 pandemic, following a steady decades-long decline. The impact of states' COVID-19 policies on mental health has received much attention; however, less is known about the impact of a broader set of long-standing and overarching state policy contexts. This study examines how working-age adults' mental health was associated with states' policy contexts over 30 years. It also assesses whether the pandemic disrupted the association and whether the association is more pronounced among adults without a college degree. METHODS: We use nationally representative data on adults ages 25-64 in the 1993-2022 waves of the Behavioral Risk Factor Surveillance System (N = 5,891,073), merged with measures of three state policy indices. The outcomes are self-rated poor mental health days in the last 30 days and extreme distress (poor mental health in all 30 days). The main independent variable is an index that summarizes states' overarching policy contexts, on a liberal-to-conservative continuum, annually from 1993-2020. Two additional indices summarize states' COVID-19 policies, one on in-person restrictions and a second on economic supports, monthly from March 2020 to December 2022. We estimate the association between states' overarching policy contexts and mental health, net of covariates, fixed differences between states, and COVID-19 policies. FINDINGS: During the study period, each unit

increase toward state policy conservatism was associated with 0.26 additional days of poor mental health and a 7% higher probability of extreme distress. The pandemic did not disrupt these associations. State policy contexts were a stronger predictor of poor mental health among adults without a college degree than adults with a degree. CONCLUSIONS: States' overarching policy contexts are an important yet understudied predictor of mental health. Current and proposed changes in state policies may have important consequences for mental health among working-age adults, their families, and communities.

► **Trends in the economic burden of mental disorders over twelve years: the Netherlands mental health survey and incidence study**

KORTELING, S. J., *et al.*

2026

The European Journal of Health Economics 27(3): 663-673.

<https://doi.org/10.1007/s10198-025-01849-5>

Mental disorders impose a substantial economic burden, making updated cost estimates essential for informed policymaking. This study provides recent cost-of illness estimates for mental disorders in the general population and examines trends over a 12-year period.

► **Corporate Consolidation And The Youth Mental Health Crisis: Evidence From Medicaid Managed Care In 2022**

MCCONNELL, K. J., *et al.*

2026

Health Affairs 45(8): 906-914.

<https://doi.org/10.1377/hlthaff.2025.01619>

Medicaid managed care organizations serve as the primary vehicle for delivering behavioral health services to low-income youth. However, market consolidation has shifted enrollment toward a handful of large national parent firms. Understanding the implications of this shift is critical for identifying and closing gaps in adolescent mental health services. Using national Medicaid claims data from 2022, we examined the associations between managed care organization ownership by five major parent firms and measures of youth mental health service use and provider composition. Managed care organizations owned by large

national parent firms were characterized by lower mental health screening rates and, for most firms, higher use of emergency department, inpatient, and medication-based care, including psychotropic prescribing without psychotherapy. Provider composition also varied by firm, suggesting differences in how these organizations structure their behavioral health networks, with some relying more heavily on psychiatrists and psychologists and others depending more on master's-level therapists. The growing influence of large national parent firms in shaping behavioral health access for Medicaid-enrolled youth underscores the need for closer scrutiny of how managed care structures serve youth with significant mental health needs.

► **Parler de son mal-être ou de ses difficultés psychologiques : résultats de l'enquête CoviPrev, mai 2022-septembre 2023**

MERTENS, C., *et al.*

2026

Bulletin Épidémiologique Hebdomadaire(8): 128-140.

En France comme à l'international, les troubles psychiques ont fortement augmenté au cours de la dernière décennie, avec une hausse marquée des états anxieux et dépressifs. Dans ce contexte, investiguer les comportements de recherche d'aide en santé mentale apparaît comme un enjeu crucial pour favoriser une prise en charge précoce. Cette étude parue dans le BEH a pour objectif d'identifier les principaux facteurs associés au fait de parler de son mal-être ou de ses difficultés psychologiques (ME-DP), à la lumière des types d'interlocuteurs sollicités

► **French psychiatrists' perspectives on proposed medical aid in dying legislation**

OLIE, E. ET COURTET, P.

2026

L'Encéphale 52(4): 358-362.

<https://doi.org/10.1016/j.encep.2025.10.006>

Introduction France is poised to legalize Medical Aid in Dying (MAiD). Such a law may have potential implications for mental healthcare. **Methods** We conducted an anonymous survey of 168 French psychiatrists between June and July 2024 to assess familiarity with the proposed law, willingness to participate in MAiD, and perceived ethical implications. **Results** Eighteen percent

of psychiatrists were unaware of the draft law, while only 9% had precise knowledge. Thirty-seven percent expressed a willingness to participate in MAiD for their patients. Concerns emerged around differentiating rational end-of-life requests from suicidal ideation driven by potentially treatable mental disorders such as depression. **Discussion** The absence of psychiatric assessment in the proposed legislation raises ethical and clinical dilemmas, particularly given the high prevalence of underdiagnosed depression in severe medical conditions. Psychiatrists find themselves balancing suicide-prevention mandates with respect for patient autonomy.

► **Soins sans consentement : du concept de dangerosité à une évaluation du risque**

OSWALD, P. ET PHAM, T.

2026

L'Encéphale 52(4): 444-448.

<https://doi.org/10.1016/j.encep.2025.09.005>

Résumé Objectif Explorer les limites des évaluations de la dangerosité psychiatrique en Belgique, France, Royaume-Uni et aux Pays-Bas, et examiner si une évaluation systématique et structurée du risque, soutenue par des compétences médico-légales et une interdisciplinarité renforcées, pouvaient améliorer les décisions de soins sans consentement. **Méthodes** Analyse comparative des cadres législatifs (loi belge du 26 juin 1990, modifiée en 2024 ; Code de la santé publique français ; *Mental Health Act 1983* ; *Wet verplichte geestelijke gezondheidszorg 2020*) et des pratiques d'évaluation, basée sur la littérature et des données statistiques. **Résultats** Les mesures de contrainte augmentent fortement en Belgique, en France, au Royaume-Uni et aux Pays-Bas depuis plus de 10 ans. Les évaluations subjectives de la dangerosité, basées sur des critères légaux flous non révisés, présentent une variabilité importante en Belgique et en France, où les échelles de risque sont absentes, contrairement au Royaume-Uni et aux Pays-Bas, qui développent des initiatives autour de l'évaluation du risque, notamment avec le HCR-20 V3 pour structurer les décisions. Ces échelles offrent une précision validée, mais leur implémentation nécessitera une formation. **Conclusions** Une implémentation d'échelles de risque, combinée à une formation interdisciplinaire et médico-légale inspirée de la ligne Nixon, pourrait réduire les biais subjectifs, la stigmatisation et les traumatismes, sous réserve d'études confirmant leur efficacité.

► **La santé mentale des jeunes exilés : vulnérabilité sociale et troubles psychiques chez les patients suivis au Comede entre 2015 et 2025**

PETIT, M., *et al.*

2026

Bulletin Épidémiologique Hebdomadaire (11): 230-238.

L'objectif de cette étude est de caractériser la population des enfants et jeunes adultes exilés venus consulter au Comité pour la santé des exilés (Comede). Elle vise à mesurer et décrire les troubles psychiques diagnostiqués chez ces patients et à identifier les facteurs associés à ces psychopathologies. Les résultats montrent l'importance des troubles psychiques chez des jeunes exilés récemment arrivés en France. Elle étaye l'existence d'associations entre exil, antécédents de violence, vulnérabilité sociale et psychopathologies chez les jeunes. À leur arrivée en France, il est donc nécessaire d'agir sur leurs conditions de vie comme d'accueil et d'améliorer leur accès aux soins médico-psychologiques.

► **Scaling up mental health services through the primary health care approach: implementation strategies from across the WHO European region**

SAGAN, A., *et al.*

2026

The Lancet Primary Care: 100184.

<https://doi.org/10.1017/s1744133123000385>

Summary Mental health conditions affect around one

in six people in the WHO European region, contributing substantially to morbidity, disability, and premature mortality. However, services too often remain under-prioritised, under-resourced, and concentrated in institutional settings. Integrating mental health services within the primary health care (PHC) approach offers a timely and necessary response, particularly as needs rise in the context of conflict, economic insecurity, climate-related crises, digitalisation, and population ageing. Despite longstanding policy commitments, implementation of community-based, PHC-oriented mental health care remains uneven and insufficient across the region. Drawing on a WHO Regional Office for Europe policy paper, we describe implementation strategies for policy and practice from across the WHO European region. We identify four key strategies for scaling up mental health services through PHC—enhancing the mental health competencies of primary care workers, integrating dedicated workers with mental health competencies into primary care teams, strengthening links between primary care and specialist mental health services, and improving collaboration between health and other sectors. Across all four strategies, the core principle is to match care to need within connected service networks anchored in PHC. Progress depends on political commitment alongside coordinated action across workforce education and training, human resources, physical resources, financing, and governance, supported by sustained efforts to reduce stigma and monitor coverage, quality, equity, and outcomes over time. Crucially, expansion of services needs to be aligned with system capacity, ensuring that increased identification of need is matched by the availability of timely and effective follow-up care.

Sociologie de la santé

Sociology of Health

► **Le travail de coopération des infirmières libérales: entre rôle propre et travail invisible**

BOUBAL, C. ET BENAMOUZIG, D.

2026

Sociologie du travail 68(2).

<https://doi.org/10.4000/16rkh>

En France, la « coordination » des professionnel·les de santé est devenue une exigence des politiques publiques, confrontées à de profondes transformations des soins ambulatoires. Comment cette norme institutionnelle se traduit-elle dans les pratiques quotidiennes des infirmières exerçant en libéral, secteur où les principes d'autonomie restent fortement valorisés ? Sur la base d'entretiens et d'observations sur trois terri-

toires, l'enquête permet de caractériser un « rôle propre de coopération » des infirmières libérales, qui reste largement informel, gratuit et ignoré des institutions ainsi que des autres acteur·ices professionnel·les. Les infirmières coopèrent avec des acteur·ices diversifié·es pour assurer le suivi des patient·es mais sans en avoir les moyens ni la reconnaissance, en raison du maintien de rapports de subordination avec les médecins, du paiement à l'acte qui invisibilise une partie de leur activité et des relations lacunaires, voire conflictuelles, qu'elles nouent avec l'hôpital.

► **Rethinking the social structuring of health: Toward an epidemiological sociology**

CONSOLAZIO, D.

2026

Social Science & Medicine 403: 119450.

<https://doi.org/10.1016/j.socscimed.2026.119450>

This paper engages with ongoing debates on the limitations of social epidemiology in explaining the social structuring of health. While the field has been highly successful in documenting the patterned distribution of health outcomes across social groups, it remains largely anchored in an epidemiological paradigm that prioritises identifying statistical associations over explaining underlying social processes. Building on this limitation, the paper argues for a reorientation towards what can be defined as an epidemiological sociology, in which sociological theory plays a central role in shaping research questions, analytical strategies, and the interpretation of empirical findings. In doing so, it argues for re-centring sociological thinking in the study of health, emphasising the role of agency, social mechanisms, and meaning-making processes. By advancing a more integrated perspective on the relationship between social conditions and health – illustrated through a critical engagement with research strands such as intersectionality, social network analysis, agent-based modelling, experimental psychosocial interventions, behavioural economics, qualitative methods, biological pathways, and neighbourhood effects – the paper contributes to ongoing efforts to bridge sociology and epidemiology. It ultimately suggests that a stronger incorporation of sociological insights can support the development of more effective and equitable public health interventions by targeting the mechanisms through which health inequalities emerge.

► **Investigating the French healthcare system from the margins: an agenda for conducting research on health centers**

MARTINACHE, I. ET VEZINAT, N.

2026

French Politics 24(2): 322-339.

<https://doi.org/10.1057/s41253-026-00320-y>

This article presents the methodological and theoretical challenges identified by means of a collective sociological investigation focused on health centers in France. These little-known but rapidly growing structures offer an alternative to the dualism that exists between public hospitals and private outpatient care in this country. In addition to providing primary care, health centers carry out public health missions while employing all of their staff, both healthcare and non-healthcare workers. However, the statuses and operating modes of health centers are broad and varied, which means that studying them proves particularly complex, both quantitatively and qualitatively. This text presents the questions raised and attempts to overcome these difficulties. It also shows that this marginal entry point into the healthcare system is characterized by certain contradictions and unique issues, highlighting the importance of the meso-sociological scale, which is too often neglected by research in this area.

► **Les centres de santé à l'épreuve de la rationalisation gestionnaire**

WETZEL, H. ET DIVAY, S.

2026

Revue Française des Affaires sociales(1): 339-359.

<https://doi.org/10.3917/rfas.261.0339>

Les centres de santé, structures sanitaires d'exercice salarié et coordonné, sont fréquemment étudiés, d'une part, pour la solution de rechange qu'ils offrent à l'exercice libéral et isolé des professionnels (para) médicaux et, d'autre part, pour la mise en œuvre de soins et de services relevant de la « médecine sociale », de la « santé communautaire » ou encore de « santé sociale ». Ils sont néanmoins soumis à des contraintes financières et leur pérennité est mise à rude épreuve du fait de modes de financement que leurs responsables et représentants jugent inadaptés. Cet article se propose d'analyser les tensions qui traversent ces centres et les actions qui s'y déroulent à l'aune d'une perspective wébérienne en termes de conflit de rationalités. La mise en œuvre de leurs objectifs éthiques et

sociaux se heurte à une rationalisation gestionnaire qui oriente les discours et les pratiques de leurs membres. Notre questionnement se concentre sur les modalités concrètes de cette gestionnarisation hégémonique, étudiée ici à trois niveaux de sa diffusion : d'abord historiquement, à travers la reconnaissance institutionnelle progressive des centres de santé ; puis, d'un point de vue organisationnel et hiérarchique, faisant des res-

ponsables de proximité des managers-gestionnaires garants du respect et de l'application des impératifs comptables et financiers ; enfin, sur le plan professionnel, en ce qui concerne les praticiens de santé amenés à maîtriser et développer parallèlement à leurs activités principales des tâches gestionnaires visant la mesure de leur travail.

Soins primaires

Primary Healthcare

► Déserts médicaux : quand le droit redessine la frontière entre médecin et infirmier

JAAFAR, D. ET KARMOCHKINE, I.

2026

Journal de Droit de la Santé et de l' Assurance maladie(46): 152-156.

Face à l'aggravation des déserts médicaux, le législateur a engagé une redéfinition progressive de la frontière entre actes médicaux et actes infirmiers. Les récentes évolutions normatives consacrent une autonomie clinique accrue de l'infirmier, notamment à travers la consultation, l'évaluation et l'orientation du patient, dans une logique d'accès direct aux soins et de coopération interprofessionnelle. Cette redistribution des compétences, sans remise en cause du monopole médical, emporte toutefois des conséquences majeures en matière de responsabilité juridique. Le droit de la santé s'oriente ainsi vers un modèle de responsabilités parallèles et complémentaires, dont la sécurisation constitue un enjeu central pour garantir à la fois l'accès aux soins et la sécurité des patients.

► Urgences dentaires : la médecine générale en première ligne ?

AMBROISE, C. ET AMADOR, G.

2026

Santé Publique 38(2): 161-173.

<https://doi.org/10.3917/spub.262.0161>

Introduction : Dans de nombreux pays, les patients souffrant de douleurs dentaires se tournent vers les médecins généralistes, bien que ces prises en charge

soient le plus souvent peu efficaces. Cette étude vise à estimer la fréquence des consultations d'urgences dentaires en médecine générale, et à décrire l'attitude des médecins face à ces situations ainsi que le parcours des patients avant et après la consultation médicale. Méthode : Une enquête observationnelle transversale a été menée à l'aide d'un questionnaire en ligne, diffusé par certaines instances professionnelles ainsi que sur les réseaux sociaux. Résultats : Au total, 342 médecins généralistes ont répondu. Parmi eux, 68 % déclarent recevoir au moins une consultation pour douleur ou infection dentaire chaque semaine. Ces consultations sont significativement moins fréquentes dans les départements à forte densité de chirurgiens-dentistes ($p < 0,001$). Tous territoires confondus, plus de 90 % des médecins rapportent que les patients évoquent fréquemment des délais de rendez-vous trop longs chez leur chirurgien-dentiste habituel ou une orientation préalable par celui-ci vers la médecine générale pour obtenir une prescription. Seul un tiers des médecins se sent confiant dans la prise en charge de ces situations, tandis que 95 % déclarent prescrire souvent, voire systématiquement, des antibiotiques. Enfin, 77 % réorientent leurs patients vers un chirurgien-dentiste. Discussion : Si les médecins généralistes sont moins sollicités dans les zones les mieux dotées en chirurgiens-dentistes, nos résultats mettent aussi en évidence une délégation de la charge des urgences dentaires de la part de ces derniers. Ce constat suggère que le recours au médecin ne dépend pas uniquement du maillage territorial, mais s'inscrit dans une dynamique plus complexe, mêlant accessibilité et disponibilité des professionnels, et représentations des patients. Conclusion : Le renforcement de la formation des médecins généralistes en santé orale pourrait améliorer leur confiance et la per-

tinence des prises en charge. Néanmoins, une réponse durable nécessite d'agir simultanément sur l'offre et sur la demande de soins : en soutenant l'implication des chirurgiens-dentistes dans les soins non programmés, en améliorant leur répartition territoriale et leur intégration dans les dispositifs de coordination, mais aussi en incitant les patients à recourir davantage aux consultations préventives.

► **Does point-of-care testing offer a positive economic impact on primary healthcare? A systematic review**

BERKTAŞ, S. A., *et al.*

2026

Health Policy 171: 105652.

<https://doi.org/10.1016/j.healthpol.2026.105652>

Background Point-of-Care Testing (POCT) offers rapid diagnostics, yet its economic efficiency in primary healthcare is not fully established. Objective To evaluate the impact of POCT on primary healthcare expenditures and cost-effectiveness compared to standard laboratory testing. Methods We searched Web of Science, Scopus, and PubMed (January 2000–January 2024) for original economic evaluations (e.g., Cost-Effectiveness, Cost-Minimization) of POCT in primary care settings. English-language studies evaluating human health outcomes were included. We assessed methodological quality using the Consensus on Health Economic Criteria (CHEC) list. Due to significant heterogeneity in study designs and perspectives, a narrative synthesis was conducted. Results Sixteen studies were included. While POCT devices often introduced higher upfront unit costs, they frequently yielded cost savings by preventing expensive secondary care referrals (e.g., ruling out Deep Vein Thrombosis (DVT), managing early pregnancy bleeding) and reducing unnecessary antibiotic prescribing. However, economic outcomes varied significantly based on the healthcare setting (societal vs. payer perspective), disease prevalence, and clinician adherence to test results. Conclusions POCT demonstrates potential for economic benefits by optimizing clinical pathways and reducing downstream resource use. However, decision-makers must account for local system capacities, as cost-effectiveness is context-dependent and not universal.

► **L'accès direct aux masseurs-kinésithérapeutes en France : enjeux cliniques et recompositions des soins primaires**

BOUDRAHEM, S.

2026

Médecine 22(5): 216-220.

<https://stm.cairn.info/revue-medecine-2026-5-page-216>

Contexte : L'accès direct (AD) aux masseurs-kinésithérapeutes (MK), progressivement introduit dans le système de santé français, constitue une évolution de l'organisation des soins primaires dans un contexte marqué par les tensions démographiques médicales, l'allongement des délais de consultation et les difficultés d'accès aux soins. Cette organisation vise à améliorer la fluidité des parcours pour certaines pathologies fréquentes, notamment musculosquelettiques, tout en réduisant la surcharge des consultations de médecine générale. Méthode : Une étude qualitative inspirée des recommandations COREQ a été menée entre janvier et novembre 2025 auprès de 47 participants : 12 MK, 14 médecins généralistes, 10 étudiants en médecine et 11 étudiants en masso-kinésithérapie. Les données ont été recueillies par entretiens semi-directifs puis analysées selon une approche thématique inductive. Résultats : Cinq thématiques principales ont émergé : l'AD comme réponse aux difficultés d'accès aux soins, les tensions autour du raisonnement clinique et du triage, la place symbolique de la prescription médicale, les différences générationnelles dans les représentations professionnelles et l'ambivalence entre coopération et concurrence. Les lombalgies aiguës et les entorses de cheville apparaissaient comme les situations les plus compatibles avec un AD sécurisé. Discussion : Les débats autour du développement de l'AD dépassent les seules questions réglementaires et interrogent les transformations des soins primaires, le partage des responsabilités cliniques et les nouvelles formes de coopération interprofessionnelle. Conclusion : Le développement de l'AD aux MK pourrait contribuer à l'évolution des soins primaires français, sous réserve d'un cadre organisationnel sécurisé, d'une formation renforcée au raisonnement clinique et d'une clarification des responsabilités professionnelles.

► **Cooperation of general practitioners in referral networks: Impact on health outcomes and costs in chronic care**

CORDES, S. ET STARGARDT, T.

2026

Social Science & Medicine 403: 119418.

<https://doi.org/10.1016/j.socscimed.2026.119418>

Effective coordination and cooperation between general practitioners (GPs) and other outpatient physicians are essential for managing chronic conditions. However, evidence on how the structure of outpatient referral networks supports such coordination and cooperation, and how it relates to patient outcomes is limited. This study examined whether GPs' structural positions within outpatient referral networks were associated with hospitalization, mortality, and health care costs in patients with chronic heart failure. Using administrative claims data from Germany, we applied social network analysis to quantify GP brokerage positions (betweenness), GP embeddedness (PageRank), and GP-cardiologist connectedness (degree). To address potential endogeneity, we used an instrumental-variable approach, combining hurdle models for hospitalization, Cox regression for mortality, and generalized linear models for costs. More central GP brokerage positions and greater GP embeddedness in the network were associated with lower probabilities of hospitalization (7.48 and 22.27 percentage points lower, respectively; all $p < 0.0001$) and lower mortality (HR = 0.7149 and HR = 0.7520; both $p < 0.0001$), with no association observed for length of stay. These positions were also associated with higher pharmaceutical costs but lower total, outpatient, and inpatient costs; for embeddedness, the corresponding effects were €412.32 ($p = 0.0052$), -€1380.49 ($p = 0.0044$), -€630.62 ($p < 0.0001$), and -€903.78 ($p = 0.0107$). Greater GP-cardiologist connectedness showed a similar pattern. These findings provide empirical evidence that structurally favorable GP positions within outpatient physician networks are associated with better outcomes and lower total costs in chronic care.

► **Canada's oral health workforce: Using long-run trends to inform rising demand for dental services**

DARK, G., *et al.*

2026

Health Policy 171: 105657.

<https://doi.org/10.1016/j.healthpol.2026.105657>

BACKGROUND: In 2023, Canada launched a publicly funded dental care plan subsidizing coverage to nine million previously uninsured individuals. This sudden expansion of coverage has raised concerns about whether there is sufficient capacity to meet demand for services. **OBJECTIVE:** To contextualize the current and future capacity of dental services in Canada. **METHODS:** This study uses a quantitative analysis of longitudinal data (1997-2023) from Statistics Canada's Labour Force Survey (LFS) to examine trends in employment levels, hours worked, and earnings for occupations in the oral health workforce. **RESULTS:** While the dentists-to-population ratio remained relatively stable over the past two decades, similar ratios for dental assistants and hygienists increased. Average weekly work hours for assistants and hygienists were relatively steady, whereas dentists' hours declined in the first half of the period. From 1997 to 2023, wages for assistants and hygienists grew roughly in line with inflation, lagging behind both sectoral and national real wage growth over this period. **CONCLUSIONS:** Canada's relatively low dentist-to-population ratio, geographic maldistribution of dentists, and slower real wage growth-particularly among assistants-may pose challenges to meeting growing labour demand for oral health personnel.

► **Do Patients Value the Service Provided by Physicians Who Overbill? A Willingness-to-Pay Study Using French Survey Data**

LAMIRAUD, K. ET VRANCEANU, R.

2026

Health Econ 35(9): 1366-1381.

<https://doi.org/10.1002/hec.70119>

Outpatient specialist physicians in France can work either in the regulated sector, where they charge the regulated fee, or in the unregulated sector, where they set their own fees above the regulated fee. This context provides a unique opportunity to estimate the extent to which patients value services provided under balance billing. In January 2021, we carried out a contingent valuation method (CVM) survey on a sample of 1051 individuals who were representative of France's adult population. Results highlighted that willingness-to-pay (WTP) for a specialist consultation in the unregulated sector was higher than for a consultation in the regulated sector, with a significant WTP difference of euro4.30 (almost 15% of the regulated fee). This difference was significant across all respondent sub-

groups (i.e., gender, age, education level, marital status, income, health status, insurance coverage, and area of residence) and was not fully driven by differences in income. Moreover, this preference for the unregulated sector was associated with the perception that specialists in this sector provide better quality medical care, better quality non-medical services, and that making an appointment with them is easier. Finally, we estimated the patient net welfare gain generated by specialist consultations in the unregulated sector in France at approximately euro165 million per year. This is the first study to provide an estimation of patients' benefits associated with balance billing.

► **La déclinaison de la réforme de la profession infirmière dans le décret socle**

MORET-BAILLY, J. ET CAUMES, C.

2026

Revue de Droit Sanitaire et Social 2026(1): 73-80.

Le décret n°2025-1306 du 24 décembre 2025 relatif aux activités et compétences de la profession d'infirmier met en œuvre le passage d'une profession à actes à une profession à missions en réorganisant les rapports entre les notions de mission, acte, activité et compétence et en consacrant de nouvelles compétences infirmières (notamment consultation, diagnostic, prescription, accès direct des patients, orientation et coordination).

► **Workforce Projections For Physicians, Nurse Practitioners, And Physician Associates**

O'REILLY-JACOB, M., *et al.*

2026

Health Affairs 45(7): 814-818.

<https://doi.org/10.1377/hlthaff.2025.01747>

Ensuring an adequate supply of clinicians is a critical policy concern. In our forecast, physician supply growth remains consistent with prior forecasts, at 1 percent annually, but the numbers of nurse practitioners and physician associates, respectively, are projected to increase 11 percent and 5.6 percent annually through 2030. The surge in nurse practitioner graduates, especially, has implications for onboarding, team-based care, and policies.

► **Sufficient and Efficient Spending on Primary Care Benefits National Health and Health Systems**

PHILLIPS, R. L., *et al.*

2026

The Milbank Quarterly 104(2): 303-323.

<https://doi.org/10.1111/1468-0009.70075>

Policy Points Primary care is undervalued and underfunded in many countries despite different care and payment models. High-quality, accessible primary care requires sustained and strategic investment. Team-based care, sustainable and engaged workforce models, and technology that enhances rather than fragments care are priorities that are shared across nations. Countries can adopt a principled approach by paying for primary care teams to care for people not physicians to deliver services; ensure that high-quality primary care is available to every individual and family in every community, and ensure that high-quality primary care is implemented with measurement and accountability. **Context** Primary care is the foundation of most health systems; yet across diverse countries, structures, policies, and payment models, it is under threat. Many high-income countries face shrinking workforces, worsening access, disrupted continuity, and reduced comprehensiveness. **Methods** Common drivers include underfunding and spending that is inefficient, leading to workforce crises and rising clinical and administrative burdens that drive burnout. **Findings** These shared challenges require shared solutions. Strengthening primary care means adequate funding that is wisely invested to increase workforce capacity-including general practitioners and other primary care team members such as nurses, pharmacists, and social workers-and promotion of sustainable models of care. Policies that impose unfunded mandates or devalue core functions such as continuity and comprehensiveness erode system performance and make it impossible for primary care to deliver on its promise for cost, utilization, satisfaction, and health outcomes. **Conclusions** Sufficient and efficient funding in team-based, person-centered primary care must be a political and policy priority.

► **Nurses' Transitions Into and Out of the Home Health Sector**

SAMSON, Z., *et al.*

2026

Med Care Res Rev 83(4): 261-273.

<https://doi.org/10.1177/10775587261422386>

Demand for home health is growing. Registered and licensed practical/vocational nurses (RNs and LPN/LVNs) are integral to the provision of home health services, but a limited body of evidence suggests that the workforce is unstable and possibly shrinking. We assessed RNs' and LPN/LVNs' transitions into and out of the home health sector using data from the Current Population Survey monthly files from January 2003 to June 2023. Specifically, we compared turnover from home health versus the hospital sector and assessed entry into home health from other health care and non-health care sectors. Turnover was consistently and significantly higher in the home health sector compared with the hospital sector. The predicted probability of nurses entering home health from any other sector hovered around or below 1%. High turnover combined with low home health entry raises concerns about home health nursing services nationwide.

► **Private Equity Acquisitions In Primary Care: Changes In Utilization, Spending, And Workforce**

SINGH, Y., *et al.*

2026

Health Affairs 45(6): 629-636.

<https://doi.org/10.1377/hlthaff.2025.01703>

Primary care is essential to advancing population health, yet it has faced underinvestment and workforce shortages in the US. Private equity (PE) investments could expand access by facilitating participation in value-based contracts and enhancing information technology capacity. However, PE's emphasis on short-term profitability may impose productivity pressures on physicians, with uncertain implications for patient care. Using a stacked difference-in-differences design and national Medicare claims data, we examined 225 PE acquisitions of primary care practices during the period 2016–22. PE acquisition increased the number of services billed and patients seen by primary care physicians by 30 percent and 11 percent, respectively. Patients in PE-acquired practices received 12.9 percent more additional services, driven by laboratory testing and the Medicare annual wellness visit. PE acquisitions also increased the total number of primary care physicians and advanced practice providers, with the latter growing at a faster rate. Taken together, our results suggest that PE investments have the potential to increase the use of primary care services, in part through greater reliance on advanced practice providers.

► **Tuberculose en Seine-Saint-Denis : incidence et rôle du Centre de lutte antituberculeuse dans les enquêtes autour d'un cas de 2018 à 2023**

VOYER, B., *et al.*

2026

Bulletin Épidémiologique Hebdomadaire (10): 209-216.

Introduction – La Seine-Saint-Denis présente le taux d'incidence de la tuberculose le plus élevé de France hexagonale. Le travail d'enquête autour des cas est assuré par le Centre de lutte antituberculeuse (Clat), rattaché au Conseil départemental. La survenue de la pandémie de Covid-19 a impacté l'épidémiologie de la tuberculose, ainsi que la réalisation des enquêtes autour des cas. Méthode – Une analyse descriptive rétrospective, par périodes de deux ans entre 2018 et 2023, de l'activité du Clat de Seine-Saint-Denis a été réalisée, comprenant une analyse des cas index de tuberculose, des sujets contacts et des enquêtes effectuées. Résultat – La Seine-Saint-Denis n'a pas connu de diminution du nombre de tuberculose maladie pendant la pandémie de Covid-19, avec 832 cas en 2018-2019 et 851 cas en 2020-2021. Dans le même temps, le nombre de sujets contacts identifiés a, lui, fortement diminué, passant de 6 379 cas à 3 782 cas. Malgré cette réduction, le dépistage parmi les contacts a pu être effectué, les taux de dépistage restant maintenus, ce qui a permis une détection stable des cas secondaires. Ainsi, 1 423 infections tuberculeuses latentes (13%) et 135 tuberculoses maladies secondaires (1%) sur 11 215 sujets contacts explorés entre 2018 et 2023, ont été diagnostiqués. Les caractéristiques des cas index ont évolué, au sein d'une population demeurant largement en situation de précarité. Les types de liens entre les cas index et leurs contacts ont également été modifiés. Discussion – L'activité de lutte antituberculeuse pendant la période du Covid-19 en Seine-Saint-Denis a été marquée par un nombre de cas de tuberculose stable, au contraire de l'évolution nationale. Une réduction du nombre de sujets contacts est constatée, mais la réalisation des dépistages a pu être maintenue.

► **The benefits of timely access to treatment: Substance use disorders, healthcare utilization and employment**

WILLIAMS, J., *et al.*

2026

Journal of Health Economics 108: 103162.

<https://doi.org/10.1016/j.jhealeco.2026.103162>

This research studies the impact of improving access to treatment for substance use disorders by reducing wait times. Linked individual-level administrative data are used to estimate the impacts of wait times on patients' treatment service utilization and employment. Potential confounding is addressed using an instrumental variables strategy that exploits exogenous variation in wait times generated by local congestion in the healthcare system. We find that longer

wait times lead to increased use of treatment services in the focal treatment episode, raised re-entry into subsequent treatment episodes, and lowered employment, consistent with patients' health deteriorating while waiting for treatment. Our calculations suggest that each dollar spent on reducing wait times yields a return of between six and seven dollars. These findings demonstrate that shortening wait times for treatment can significantly reduce the economic and social burdens of addiction.

Systèmes de santé

Health Systems

► Le NHS : une « religion » en crise ?

BUBIEN, Y.

2026

Sève : Les Tribunes de la Santé(86): 45-58.

Le *National Health Service* (NHS), système de santé publique britannique créé en 1948, est l'un des piliers de l'État-providence outre-Manche. Véritable « religion » nationale, il incarne un idéal de solidarité, garantissant un accès gratuit aux soins pour tous, financé par l'impôt. Ce modèle *beveridgien* diffère fondamentalement du modèle français, fondé sur les cotisations sociales. Bien qu'encore largement plébiscité par la population et les différents partis politiques, le NHS traverse aujourd'hui une crise systémique accentuée par le Brexit. Les réformes inspirées du *New Public Management*, les partenariats public-privé, ainsi qu'une gouvernance axée sur la performance et la marchandisation, ont fragilisé ses fondements. Pénuries de personnel, sous-équipement, listes d'attente interminables, désengagement de l'État et externalisation des soins sont autant de symptômes d'un mal profond. Si le gouvernement travailliste issu des élections de 2024 entend réformer en profondeur le NHS, la soutenabilité de ce modèle solidaire est plus que jamais remise en question dans un contexte de tensions budgétaires, de vieillissement démographique et de pression privatisante.

► Constructing effectiveness as a general legal principle of public healthcare systems: comparative insights from France, Germany, and England

DOMENICI, I., *et al.*

2026

Health Economics, Policy and Law 21(2): 137-155.

<https://doi.org/10.1017/S1744133126100371>

In public healthcare systems, effectiveness is a central requirement for determining which services should be offered and reimbursed. Yet, due to its technical nature and to the need for specification through specialised bodies, the nature of this principle remains underexplored. This article bridges the gap by conducting a comparative analysis of effectiveness' operation in three distinct healthcare systems: Germany, France, and England. We argue that effectiveness can be recognised as a foundational legal principle governing reimbursement decisions, revealing a substantive and a formal dimension. Substantively, effectiveness requires a consideration of an intervention's ability to bring about a clinical benefit, accounting both for its desired outcomes and its risks. The applied evidentiary standard calls for a careful scrutiny of the available scientific evidence, as well as the state of medical knowledge. The exceptions to this standard are extremely limited and do not undermine the validity of the wider principle. Formally, the article emphasises the central role that administrative authorities conducting Health Technology Assessment (HTA) play, with delegated decisions ranging from the definition of the applica-

ble evidentiary standards to the issuing of binding guidelines. It is argued that mechanisms must be put in place to ensure these bodies' expertise, independence, and transparency.

► **What Happens When Coverage is Cut? Looking Backward and Forward From the One Big Beautiful Bill**

GAFFNEY, A., *et al.*

2026

The Milbank Quarterly 104(2): 324-360.

<https://doi.org/10.1111/1468-0009.70082>

Policy Points The One Big Beautiful Bill Act (OBBBA) may impose the largest coverage losses in US history, causing the number uninsured to rise by 55% in the coming decade. We examined four prior coverage contractions - Reagan-era Medicaid cuts, the 2005 TennCare disenrollment, 2019 Arkansas work requirements, and the Medicaid Unwinding-to shed light on the OBBBA's impacts. These suggest that most who lose Medicaid do not find alternative coverage, and that states are unlikely to compensate for federal cuts, findings that run counter to some assumptions adopted by the Congressional Budget Office in predicting the impacts of Medicaid cuts. Studies of coverage contractions complement data from coverage expansions in predicting worse health care access, household finances, and health for needy individuals due to the OBBBA. Studies also suggest that the magnitude of harms from contractions may exceed that suggested by expansions. **Context** The so-called One Big Beautiful Bill Act signed into law by President Trump on July 4, 2025 will cut \$1 trillion from federal health care programs over the coming decade and cause 10 million individuals to become uninsured according to the Congressional Budget Office. Most analyses of the bill's impacts have assumed they would be the inverse of those documented from previous coverage expansions. An examination of past coverage cuts might yield additional insights into the probable impacts of this legislation on the medical care and health of the needy. **Methods** We reviewed studies of four prior large scale coverage contractions: Reagan-era Medicaid cuts, the 2005 TennCare Disenrollment, the 2019 implementation of work requirements in Arkansas, and the postpandemic ? Unwinding? of Medicaid. **Findings** The experience of these prior coverage contractions complements evidence from analyses of coverage expansions in predicting that widespread insurance loss will lead to a reduction in care utilization, an increase in

household financial strain, and worsened physical and mental health for low-income individuals. These coverage contractions additionally suggest that most who lose Medicaid coverage will not find alternative coverage; that work requirements will impose burdensome administrative costs on states; that states are unlikely to offset reductions in federal Medicaid funding with internal funds; and that the second-order effects of coverage losses may, in some instances, be greater (in magnitude) than the benefits seen after coverage expansions. **Conclusions** Cuts to federal health care programs will produce sharp contractions in public coverage that will worsen existing problems in US health care such as insurance churn, degrading care, and worsening health inequality. While states may take some steps to mitigate harmful impacts, better protection of the medically needy would require repeal of the legislation, while full protection would require universal, seamless coverage.

► **Priority setting for health equality – searching for an ethical framework**

GERMAIN, S. ET NEWDICK, C.

2025

Health Economics, Policy and Law 21(2): 251-264.

<https://doi.org/10.1017/S1744133125100224>

Compounded by 14 years of public welfare austerity, health equality presents a challenge that extends beyond healthcare in isolation because it also engages the more recondite politics of public health. Recent policy has addressed the issue by requiring National Health Service (NHS) bodies to integrate their services with those of local authorities. We consider how this adds significant new difficulty to the already complex process of NHS resource allocation. We argue that these duties require a new framework to gauge the values, evidence and criteria needed to set priorities for public health; not simply as a desirable objective, but a necessity in law. We consider current approaches to priority setting for medical treatment, and the responses already offered by current ethical frameworks. We then discuss the new ethical, political, and practical challenges posed by public health priority setting for health equality. Informed by this context, we engage an intersectional lens to explore a "non-ideal" solution grounded in Professor Sir Michael Marmot's framework to reduce health inequalities.

► **Healthcare reform in the Netherlands: after 15 years of regulated competition**

MAARSE, H. ET JEURISSEN, P.

2024

Health Economics, Policy and Law 21(1): 121-132.

<https://doi.org/10.1017/S1744133123000385>

This article discusses the results and prospects of the market reform in Dutch health care which came into force in 2006. Attention is paid to the results of the health insurance reform, the experience with the shift from passive to active purchasing and the impact of the reform on healthcare provision and cost control respectively. Other topics discussed are the consequences of the reform for administrative costs, institutional trust in health insurance, and the power balance in health care after reform. The central message is that the high expectations of the market reform have not come true. Dutch health care features a high degree of hybridity and there are indications that the system is becoming ever more hybrid: the system operates much less market-like than the market frame suggests. Currently, the policy narrative on the reform is changing. Policymakers and policy documents underscore the need for cooperation in provider networks and more state direction. The Dutch experience with health care reform illustrates the pendulum theory. After a period of a belief in competition and less state direction the pendulum in policymaking swings back to a belief in cooperation and a pro-active role of the state.

► **La réforme du système de santé danois : entre rupture et inspirations pour la France**

PANNETIER, J.

2026

Seve : les tribunes de la sante(86 (en ligne)): 59-69.

La réforme du système de santé danois de 2007 illustre une transformation systémique ambitieuse, fondée sur une vision stratégique à long terme. Confronté aux défis du vieillissement, des maladies chroniques et des contraintes budgétaires, le Danemark a opéré une refonte radicale reposant sur trois piliers : une réorganisation territoriale majeure, une modernisation hospitalière centrée sur la concentration des plateaux techniques, et un renforcement des soins primaires. Quinze ans après sa mise œuvre, le bilan est contrasté : infrastructures modernisées, maîtrise budgétaire exemplaire et amélioration des indicateurs de santé, mais aussi persistances d'inégalités territo-

riales et tensions sur les ressources humaines. Sans être transposable tel quel, ce modèle offre des pistes de réflexion pour la France : repenser la gouvernance sanitaire entre pilotage national et autonomie régionale, redéfinir l'articulation entre public et privé, mieux intégrer la prévention dans les politiques et adopter une approche populationnelle. L'expérience danoise rappelle qu'une réforme réussie repose sur une vision politique cohérente et un financement pluriannuel seuls capables de répondre aux défis contemporains de la santé publique.

► **La fin de vie : perspectives internationales**

PAPADOPOULOU, N.

2026

Journal de Droit de la Santé et de l'Assurance maladie(46): 7-109.

Ce dossier expose l'état du droit en matière de fin de vie en Belgique, aux Pays bas, en Espagne, en Angleterre et au Pays de Galles, en Suisse, en Allemagne, en Italie et au Canada. Les contributions réunies montrent que, loin d'être uniforme, la régulation juridique de la fin de vie se décline selon des modèles multiples, façonnés par les traditions juridiques, les cultures médicales et les choix éthiques propres à chaque société. L'approche comparative permet ainsi de mettre en lumière les convergences, mais aussi les divergences profondes qui caractérisent les réponses apportées par les différents systèmes juridiques. Vous trouverez également dans ce dossier la présentation du cadre législatif positif français ainsi que les perspectives d'évolution portées par les débats législatifs actuellement en cours. La réflexion de chacun sur cette évolution législative française.

► **Political distrust and confidence in medical institutions in the United States: An institutional spillover perspective**

SULEMAN, D. B. ET EDET, R.

2026

Social Science & Medicine 403: 119387.

<https://doi.org/10.1016/j.socscimed.2026.119387>

Background Confidence in medical institutions is a critical component of population health, shaping individuals' willingness to seek care, adhere to treatment, and comply with public health guidance. While prior research has emphasized demographic determinants

of medical trust, comparatively less attention has been paid to the broader sociopolitical context in which institutional confidence is formed. Drawing on the institutional spillover perspective, this study examines whether distrust in political institutions is associated with lower confidence in medical institutions in the United States. **Methods** Using pooled cross-sectional data from the 2016, 2018, 2022, and 2024 waves of the General Social Survey (GSS) (n = 6603), we estimate survey-weighted ordinal logistic regression models to assess the relationship between political distrust and confidence in medical institutions. Political distrust is operationalized as an index of confidence in the executive branch, Congress, and the Supreme Court, while confidence in medical institutions is measured using respondents' reported confidence in "medicine". Models adjust for sociodemographic, socioeconomic, and political covariates, and include an interaction

term to assess variation across pre- and post-COVID periods. **Results** Results indicate a robust and statistically significant association between political distrust and lower confidence in medical institutions. A one-unit increase in political distrust is associated with approximately a 37% reduction in the odds of reporting higher levels of confidence in medicine, net of covariates. This relationship persists across model specifications and is modestly stronger in the post-COVID period. **Conclusion** These findings provide empirical support for the institutional spillover perspective, suggesting that distrust in political institutions may extend beyond the political domain to shape public evaluations of medical institutions. The results underscore the importance of considering political distrust as a broader structural determinant of health-related attitudes in contemporary U.S. society.

Travail et santé

Occupational Health

► The labor and health economics of breast cancer

AHAMMER, A., *et al.*

2026

Journal of Health Economics 108: 103141.

<https://doi.org/10.1016/j.jhealeco.2026.103141>

We estimate the long-run labor market and health effects of breast cancer among Austrian women. Compared to a random sample of same-aged non-affected women, those diagnosed with breast cancer face a 22.8 percent increase in health expenses, 9 percent lower unconditional earnings, 5.8 lower employment probability, and an earnings penalty conditional on employment of 6.4 percent five years after diagnosis. We discuss changes in job quality, hours, incapacitation, and employer discrimination as potential mechanisms behind these labor market adjustments.

► Determinants of disability pension following sickness absence in French private-sector employees

BEN HALIMA, M. A., *et al.*

2026

European Journal of Public Health 36(4): ckag094

<https://doi.org/10.1093/eurpub/ckag094>

Disability pension represents a major public health challenge in France, with 843 000 beneficiaries and €8.5 billion expenditure in 2022. The transition from sickness absence to disability pension remains insufficiently documented in the French context. This study identifies risk factors for disability pension among French private-sector employees to inform targeted prevention strategies. We conducted a retrospective cohort study of 228 514 employees from a complementary health insurer (2018–23), encompassing 364 762 sickness absence episodes. Risk factors for transition to disability pension were analyzed using Kaplan–Meier survival and Cox proportional hazards models stratified by absence duration, adjusting for sociodemographic, employment, organizational, and health-related factors. Of all episodes, 6404 (1.8%) progressed to disability pension. Risk was particularly high

among individuals aged ≥ 50 years and among those in higher-risk socio-professional groups, notably executives and individuals belonging to the “Other” category (including farmers, merchants, and business owners), compared with employees. Increased risk was also observed among workers in the lowest income quartile and among employees in large companies. Long-term sickness absence (>180 days) was associated with a higher risk of disability pension. Therapeutic part-time work reduced risk only for short absences. Most risk factors lost predictive power beyond 12 months, with declining effect sizes over time. This study identifies a critical 12-month intervention window. Early interventions should prioritize therapeutic part-time work and strengthen targeted support for older workers, executives, and large company employees to reduce disability pension transitions and curb rising costs.

► **Labor market entry prospects of people with visual impairments: evidence from administrative register data in the Netherlands**

DIEHL, K., *et al.*

2026

The European Journal of Health Economics 27(3): 509-526.

<https://doi.org/10.1007/s10198-025-01830-2>

The UN’s Convention on the Rights of Persons with Disabilities includes a right to equal work opportunities. People with visual impairments (VI) are targeted by this convention and experience low employment rates. The initial transition from education to labor is a predictor for later labor market participation. Exploiting administrative register data, we identified a graduated subpopulation with VI and matched them to a control group. This paper evaluates (1) group differences in various socio-economic outcomes following graduation, and (2) following initial employment. Following graduation there are fewer transitions into (self-)employment for people with VI and more transitions to disability insurance or social benefits, but similar patterns for unemployment insurance and further education. Scrutinizing subsequent dynamics for those that secured initial employment revealed a greater share of those with VI maintained employment as dominant source of income given there was a change in employment status. However, there are more dynamics recorded for individuals with VI, which may reflect difficulties retaining a job. This group remained overrepresented in disability insurance as well as social

benefits. Differences with regards to self-employment, unemployment insurance, further education and the other no income status did not reach significance. In conclusion, this study did not find equal labor market prospects for declarants with VI. The finding that VI declarants face less favorable labor market prospects than their matched counterparts, despite having similar cognitive ability, underscores the need for policies that not only improve their labor market outcomes but also promote greater equality in opportunities to reach the UN convention’s ideals.

► **To what extent does exposure to psychosocial risks impact workers’ mental health? Evidence from France**

GAILLARD, A., *et al.*

2025

Journal de Gestion et d’Economie de la Santé 3(3): 57-93.

<https://doi.org/10.54695/jdds.043.3.0057>

Background: Mental health disorders is increasingly the result of adverse working conditions. In several European countries, ever more workers are reporting work-related mental health problems and stressful working conditions. This paper aims to assess the impact of exposure to psychosocial risks (PSRs) at work on French workers’ mental health. Methods: The research is based on the French “Health and employment history” survey and focuses on workers employed in the private sector in 2010. Exposure to PSR is measured using a job-demands index, a decision-latitude index and their combination as a job-strain index. We use symptoms of major depressive episodes (MDEs) as a measure of workers’ mental health. Results: Results from a simple Probit Model show that individuals in demanding jobs have a significantly higher probability of suffering from MDEs than individuals less exposed to the demands of work. We find similar results for decision latitude with a smaller effect on mental health. These results are confirmed when we control for potential endogeneity of PSRs through an instrumentation strategy. Indeed, among workers, the probability of suffering from MDEs increases with job-demands and decision-latitude exposure, from less than 2% among the bottom decile on the exposure scale to more than 8% among the top decile. Conclusion: This study confirms with econometric methods that exposure to PSR is a crucial phenomenon for companies to consider in order to preserve workers’ health and especially mental health that play an important role for the mainte-

nance of employment and the return to employment.
JEL: J81, J28, I18

► **Analyse de la souffrance des soignants à travers le dispositif SPS**

GEORGESCU, I., *et al.*

2026

Santé Publique 38(2): 217-224.

<https://doi.org/10.3917/spub.262.0217>

Introduction : La question de la souffrance professionnelle des soignants occupe une place croissante dans le débat public et scientifique en France. Dans ce contexte, cette étude examine les souffrances exprimées lors d'appels à la plateforme SPS de 2016 à 2024. Méthode : Le matériau est composé de 34 920 appels et 330 verbatims, analysés selon une méthode mixte. Résultats : Les résultats montrent une hausse régulière de l'expression de la souffrance chez les soignants (de 220 appels en 2016 à 7 005 en 2024), une prédominance des difficultés organisationnelles (42,4 %) dans les causes exprimées (intensification des exigences institutionnelles, manque de reconnaissance et dégradation du climat au sein des équipes) et une expression présente parmi toutes les professions. Conclusion : Cette étude confirme des constats déjà établis, en affirmant néanmoins l'importance du rapport au travail comme raison principale de la souffrance des soignants. Elle suggère la nécessité de mener des actions de soutien sur le plan individuel et de management au niveau des équipes de soins, et dans les relations hiérarchiques.

► **The Impact of Unemployment Insurance Benefit Cuts on Mental Health: Evidence From Early Pandemic Program Expirations**

GUO, X., *et al.*

2026

Health Economics 35(9): 1382-1396.

<https://doi.org/10.1002/hec.70122>

ABSTRACT This study is the first to estimate the effects of unemployment insurance (UI) benefit contractions on mental health. We leverage a unique quasi-natural experiment: early termination of the Federal Pandemic Unemployment Compensation (FPUC) and Pandemic Unemployment Assistance (PUA) programs across more than 20 states during the summer of 2021. Using high-frequency data from the Census Bureau's Household Pulse Survey (HPS), our difference-in-dif-

ferences estimates suggest that early withdrawal from FPUC and PUA increases the probability of reporting anxiety symptoms among working-age adults without a college degree, a group particularly vulnerable to unexpected income shocks. The adverse effects are more pronounced among racial and ethnic minorities, older individuals, and women. However, the increase in anxiety symptoms is short-lived, persisting for about 1 month after the benefit cessation. Finally, we find evidence that financial hardship is a likely mechanism underlying these findings.

► **Bridging success in the labour market: does continuity of general practitioners' care matter for individuals with common mental disorders?**

ISLAM, M. K., *et al.*

2026

The European Journal of Health Economics 27(6): 1277-1291.

<https://doi.org/10.1007/s10198-025-01882-4>

Mental illnesses impose substantial burdens on individuals, families, and society, encompassing both severe personal consequences and high societal costs. This study examines whether improved continuity of care with regular general practitioners (RGP-CoC) is associated with better labour market outcomes for individuals diagnosed with common mental disorders (CMDs). Using administrative registry data for 139,873 individuals with CMDs (N=371,825 observations) from 2014/15 to 2017/18, we construct RGP-CoC indices within rolling two-year windows and track labour market outcomes over subsequent one-year periods. We employ a lagged design and high-dimensional fixed-effects models to robustly assess the association between RGP-CoC and labour market outcomes over the period 2016–2019. Our findings show that higher RGP-CoC is associated with improved labour market outcomes, with stronger and more robust effects observed for wage income than for employment probability. We also find a significant negative association between RGP-CoC and the likelihood of sickness absence. While the effects vary across education levels, no significant gender differences are observed. These findings highlight the vital role of RGP continuity of care in improving labour market participation and earnings, especially for individuals with CMDs. Enhancing continuity with a regular GP as a core quality metric in primary care can inform healthcare policy and support broader goals of economic inclusion.

► **La santé au travail : un levier stratégique pour une politique de prévention active en santé publique**

LARAQUI, C. E. H., *et al.*

2026

Bulletin de l'Académie Nationale de Médecine
210(5): 647-656.

<https://doi.org/10.1016/j.banm.2026.01.025>

Résumé Introduction La santé au travail (SAT), reposant sur une approche pluridisciplinaire, constitue un levier stratégique pour une politique de prévention active en santé publique (SP). Confrontée à l'émergence croissante de pathologies liées tant aux modes de vie qu'aux conditions de travail, elle ne se limite plus à la prévention des risques professionnels et adopte désormais une approche intégrée, centrée sur la santé globale. Objectif Analyser le rôle stratégique de la SAT dans une politique de prévention active, à travers l'élargissement de ses missions, son articulation avec les politiques publiques de santé, les obstacles à son intégration et les perspectives d'amélioration. Méthode Une revue narrative de la littérature scientifique, institutionnelle et réglementaire a été réalisée, complétée par une analyse comparative des dispositifs et pratiques de santé au travail en lien avec les Plans et Programmes nationaux de SP. Résultats La SAT joue un rôle central dans la prévention des risques professionnels, la promotion de la santé globale, l'accès aux soins pour des populations défavorisées et la production de données épidémiologiques utiles à la veille sanitaire. Elle constitue un relais opérationnel des politiques de SP. Toutefois, son intégration reste entravée par des cloisons institutionnelles, l'hétérogénéité des dispositifs et l'insuffisance de coordination intersectorielle. Conclusion Le renforcement de l'articulation entre la SAT et la SP implique une gouvernance partagée, une reconnaissance institutionnelle renforcée, la mutualisation des données et le développement d'outils communs. Cette approche intégrative, fondée sur une dynamique synergique entre prévention des risques professionnels, promotion de la santé et protection des populations, permet d'optimiser l'efficacité, l'équité et la durabilité des politiques de prévention, tant à l'échelle individuelle que collective.

Introduction Occupational health (OH), based on a multidisciplinary approach, represents a strategic lever for an active public health (PH) prevention policy. In response to the growing emergence of diseases linked to both lifestyle and working conditions, it has moved beyond the sole prevention of occupational hazards and now adopts an integrated approach focused on

overall health. **Objective** To analyze the strategic role of OH in an active prevention policy, by examining the broadening of its missions, its alignment with PH policies, the obstacles to its integration, and the prospects for improvement. **Method** A narrative review of scientific, institutional, and regulatory literature was conducted, supplemented by a comparative analysis of OH systems and practices, particularly in connection with National Public Health Plans and Programs. **Results**

► **Telework perceptions in hospital workers throughout the COVID-19 pandemic — the ADAPTAWORK2 study**

MOURGUES, C., *et al.*

2026

European Journal of Public Health 36(3).

<https://doi.org/10.1093/eurpub/ckag064>

The COVID-19 pandemic has changed work organization in hospitals, notably with the expansion of telework. This study aimed to assess perceptions of telework among hospital workers throughout the pandemic and to identify factors associated with telework perceptions in the post-pandemic period. An observational cross-sectional study was conducted from October to December 2023. All hospital workers, regardless of their occupation or status, were invited to participate in an online survey. Perceptions of telework were assessed using visual analog scales, ranging from 0 (very negative) to 100 (very positive), across three periods: before the COVID-19 pandemic, during the first French lockdown, and after the pandemic. A total of 882 hospital workers were included in the analysis. Throughout the pandemic, 41.4% reported adopting telework. Overall, perceptions of telework became significantly more positive over time, rising from a mean score of 54.3 ± 25.3 before the pandemic, to 62.7 ± 27.4 during the first lockdown, and to 66.0 ± 27.5 after the pandemic ($P < .001$). Experiencing telework for the first time was associated with more favorable perceptions, with high levels sustained among those who continued teleworking post-pandemic. Perceptions of telework improved significantly among hospital workers throughout the pandemic with notable shifts in work practices, with nearly one third of participants teleworking in the post-pandemic period. Experiencing telework was associated with more positive perceptions.

► **Points-Based Attendance Systems Associated With Presenteeism Despite Paid Sick Leave Protections**

SLOPEN, M., *et al.*

2026

Health Affairs 45(6): 684-691.

<https://doi.org/10.1377/hlthaff.2025.00995>

Presenteeism, or attending work despite being ill enough to warrant absence, is endemic among working Americans. Although research suggests that paid sick leave mandates reduce presenteeism, it has not considered whether workers exposed to points systems for work attendance are more likely to work while sick or how points systems may interact with paid sick leave mandates. We used 2024 data from the Shift Project on service workers employed at sixty-three large firms to study the relationship between points systems and presenteeism and to determine whether that relationship varied by employee coverage under a paid sick leave law. We found that exposure to a points system was associated with an 18.9-percentage-point increase in presenteeism, with effects observed even among workers who had not incurred points. Paid sick leave mandates did not moderate exposure to a points system or the association between exposure to points systems and presenteeism. Results suggest that points-based attendance systems undermine the public health benefits of paid sick leave mandates. To reduce presenteeism in jurisdictions with paid sick leave mandates, outreach to covered workers and employers and stronger enforcement efforts may be needed.

► **Getting better or worse? How trends in healthy life expectancy within working age are shaped by diverging trends among age groups**

TETZLAFF, J., *et al.*

2026

European Journal of Public Health 36(3). ckag059

<https://doi.org/10.1093/eurpub/ckag059>

Against the backdrop of population ageing and growing labour shortage, Healthy Life Expectancy (HLE) in working age represent a key resource for individual wellbeing and economic growth. This study investigates how age-specific trends shape the development of HLE within working age and whether these trends differ between health indicators. We used the German Socioeconomic Panel to calculate HLE between age 18 and 64 for three periods between 2002 and 2022

(N = 232 393) based on Self-rated Health (SRH), mental and physical Health-related Quality of Life (p/mHRQoL). We decomposed changes in HLE over time into the contributions by age group and distinguished between morbidity and mortality contributions. For men, HLE increased in terms in SRH but remained largely unchanged in terms of mHRQoL and pHRQoL. For women, HLE decreased in terms of SRH and pHRQoL while it remained stable for mHRQoL. Deteriorating health in younger working-age groups strongly contributed to decreases in HLE while improving health at older working age fostered increases in HLE. Mortality contributions were minor. We found divergent contributions to trends in HLE by age group with the younger working-age population fostering decreases in HLE while older age groups fostered an increase. Furthermore, trends differed by health indicator, which underlines the importance of analysing more than one indicator whenever possible. The findings are worrying and suggest that the labour force may decline not only due to population ageing, but also due to the deteriorating health, posing growing challenges for both health and labour market policies.

Ageing

► Life course socio-economic effects in later life cognitive functioning by cohort, gender and origin

ABULADZE, L. ET SAKKEUS, L.

2026

Social Science & Medicine 402: 119333.

<https://doi.org/10.1016/j.socscimed.2026.119333>

Later life cognitive health depends on both individual as well as broader structural characteristics, with health inequalities rooted in the long-term organisation of social life. This paper examines a context of social transformation into and out of state socialism, affecting the distribution and accumulation of resources differently across population groups. We analyse later life cognitive health by cohort, gender, and migrant origin, including respondents aged 50 and over from SHARE Estonia (2010-2022), who report information on variables of interest (N = 5170). The roles of childhood and adulthood socio-economic positions (SEP) are analysed separately in a restricted sample (N = 2907). Using hybrid and correlated random-effects models, we distinguish within- and between-person effects in verbal recall change for two cohorts – those born in 1930-44 and 1945-59. We find steeper individual verbal recall decline in general for men, but not for migrants, in both cohorts. Gendered cognitive trajectories were not origin- or cohort-specific. Regarding the role of life course socio-economic factors in later life health, we find support for the sensitive period model, the pathway model and the accumulation model.

► Représentations des professionnels des EHPAD à l'égard des soins palliatifs : étude qualitative multisite

BAGARAGAZA, E., *et al.*

2026

Santé Publique 38(2): 175-187.

<https://doi.org/10.3917/spub.262.0175>

Introduction : L'intégration de la démarche palliative précoce dans le parcours de soins des résidents en établissements d'hébergement pour personnes âgées dépendantes constitue un défi majeur de santé publique et relève de plusieurs facteurs. But de l'étude : Cette étude vise à explorer les représentations des pro-

fessionnels à l'égard des soins palliatifs, afin de comprendre l'impact de ces représentations sur l'adoption de la démarche palliative dans l'accompagnement des résidents. Méthodes : Une étude qualitative utilisant une approche d'étude de cas multiple a été réalisée. Des entretiens individuels semi-structurés et des entretiens de groupe ont été conduits auprès de professionnels provenant de 21 EHPAD dans trois régions françaises. L'analyse thématique a été privilégiée. Résultat : Au total, 68 entretiens individuels et neuf entretiens de groupe réunissant 67 professionnels ont été réalisés. L'analyse des récits des participants met en évidence des représentations collectivement partagées, qui structurent leur rapport aux soins palliatifs, circonscrits à la notion d'accompagnement et dont les visées sont multiples et les pratiques plurielles. Les soins palliatifs sont associés à la phase terminale de la maladie et à la fin de vie et relèvent de l'expertise médicale d'une équipe spécialisée. Ces représentations constituent un frein à l'appropriation de la démarche palliative et à son intégration dans les soins. Conclusion : Pour soutenir l'intégration optimale de la démarche palliative en EHPAD, les actions visant à faire évoluer les représentations au niveau individuel, clinique et organisationnel et à co-construire une culture institutionnelle partagée favorisant l'accès aux soins palliatifs au moment opportun sont à mettre en œuvre.

► Retirement and cognitive abilities: Evidence from the German early retirement age reform for women

BERGSCHNEIDER, H., *et al.*

2026

Journal of Health Economics 108: 103161.

<https://doi.org/10.1016/j.jhealeco.2026.103161>

We study the effects of retirement on cognitive functioning among women aged 63 to 67 by exploiting a German retirement reform that raised the early retirement age for women born after 1951 by three years, from 60 to 63. Our indicators of cognitive functioning are objective cognitive test scores (word recall, semantic fluency, and the Stroop test) from a large biomedical dataset, as well as the diagnosis of cognitive disorders from administrative health insurance claims. We find reductions of around 13% of a standard deviation per

year in retirement for measures of fluid intelligence, whereas crystallized intelligence remains unaffected. These estimates reflect the reform-induced shift in retirement duration for compliers around the eligibility cutoff. In contrast, additional years in retirement do not affect diagnosis of cognitive disorder and decrease diagnoses of dementia-related risk factors such as hypertension, depression, and sleep problems. The improvement in health outcomes suggests that cognitive decline is not driven by health deterioration but might possibly be due to reduced cognitive engagement after leaving work.

► **Aidant un jour, aidant toujours ?
Les enseignements d'une enquête
exploratoire sur la post-aidance en France**

CHAMBON, M., *et al.*

2026

Revue des Politiques Sociales et Familiales 157(2): 121-133.

<https://doi.org/10.3917/rpsf.157.0121>

Grâce aux données de la première enquête exploratoire réalisée en France auprès d'anciens aidants (N = 456), cet article s'attache à décrire la post-aidance et à comprendre dans quelle mesure elle s'inscrit dans des formes de continuité avec la période de l'aidance. Au moment où leur rôle prend fin, d'abord, les répondants éprouvent souvent une sensation de vide et n'ont que rarement anticipé ce que serait leur vie après l'aidance, notamment lorsque cette dernière était très fréquente et que leur proche est décédé. Ensuite, les conséquences de l'aidance sur la santé, la vie sociale et la carrière persistent bien après que leur rôle ne s'arrête, que ce soit négativement ou positivement. Les anciens aidants, enfin, développent souvent de nouvelles activités d'accompagnement dans le cadre familial, qu'elles soient bénévoles ou professionnelles. Les bénéfices de l'accompagnement des aidants dans la post-aidance sont examinés.

► **Trends In Care Needs Among Older
US Adults Diverged By Age, 2011–22**

FREEDMAN, V. A., *et al.*

2026

Health Affairs 45(7): 790-798.

<https://doi.org/10.1377/hlthaff.2025.01355>

Changing late-life disability and care patterns that may accompany population aging have profound conse-

quences for the nation's health and related public policies. Drawing on two cross-sectional rounds of the National Health and Aging Trends Study, we examined trends among US adults ages 65 and older in 2011, when the oldest members of the baby-boom generation turned age 65, and in 2022, when about half of the generation was ages 65–74. We found increases in the percentage of adults ages 65–74 who reported activity limitations, receiving paid care in the community, and having unmet care needs. In contrast, for older age groups, we found declines in the receipt of care overall and in residential settings, particularly nursing care, without increases in unmet care needs. All else equal, had the sociodemographic and health profile of the group ages 65–74 not differed from the preceding cohort—especially in terms of increased educational attainment—the increases experienced by this age group would have been even larger. Findings portend growing challenges in caring for older US adults in the future.

► **Reforming the funding of long-term care
for older people: costs and distributional
impacts of planned changes in England**

HU, B., *et al.*

2026

Health Economics, Policy and Law 21(3): 285-305.

<https://doi.org/10.1017/S1744133125000088>

Reforms to the means tests in England for state-financed long-term care were planned for implementation in 2025. They included a lifetime limit (cap) on how much an individual must contribute to their care, with the state meeting subsequent care costs. We present projections of the costs and distributional impacts of these reforms for older people, using two linked simulation models which draw on a wide range of data. We project that by 2038 public spending on long-term care for older people in England would be about 14% higher than without the reforms. While the main direct beneficiaries of the lifetime cap would have been the better off who currently receive no state help with their care costs, the reforms also treated capital assets more generously than the current system, helping people with more modest incomes and wealth. When analysing the impacts of the reforms it is therefore important to consider the whole reform package. Our results depend on a range of assumptions, and the impacts of the reforms would be sensitive to the levels of the cap and other reformed parameters of the means test on implementation.

► **Hospice Acquisitions By Certain Firms And Corporations Were Associated With Reductions In Care Intensity, 2010–21**

WEN, J., *et al.*

2026

Health Affairs 45(8): 897-905.

<https://doi.org/10.1377/hlthaff.2025.0153>

The rapid growth of private equity (PE) and publicly traded corporation (PTC) ownership in hospice has raised concerns that investor-driven profit incentives may undermine care quality. Evidence on how these acquisitions affect care delivery remains limited. We linked a national PE and PTC acquisition database to Medicare claims for a beneficiary sample for the period 2010–21 and used a difference-in-differences event study to compare acquired versus nonacquired for-profit hospices on process-based quality measures and Medicare reimbursement. After PE acquisition, registered nurse, social worker, and home hospice aide minutes per thirty days declined 5.14 percent, 12.32 percent, and 6.62 percent, respectively; after PTC acquisition, registered nurse and home hospice aide minutes per thirty days declined 4.63 percent and 9.09 percent. Declines in visit minutes also were observed in the last seven days of life. Reductions in visit minutes were driven by four large acquirers. These findings highlight the need for increased transparency and oversight policies, as well as payment reforms that align reimbursement with care intensity and quality.

► **Unmet needs and fall risk among older adults: evidence from Europe using SHARE data**

KINGSADA, A., *et al.*

2026

European Journal of Public Health 36(4) : ckag088

<https://doi.org/10.1093/eurpub/ckag088>

Falls are a significant cause of disability, hospitalization, and loss of autonomy in older adults. Although unmet care needs are known to worsen health outcomes (e.g. reduced quality of life, disability), their association with fall risk among frail community-dwelling older adults remains unclear. This study examines this relationship. We used panel data from waves 6–9 (2015–22) of the Survey of Health, Ageing and Retirement in Europe for adults aged 50+. The analytic sample included 872 non-frail individuals (3001 observations) and 1061 frail individuals (3552 observations). We examined the association between unmet needs for assistance with activ-

ities of daily living and falls among frail and non-frail individuals. Two-way fixed effects models with lagged exposures were estimated to account for time-invariant individual heterogeneity and reduce reverse causality. Analyses distinguished between unmet formal and informal care needs. Among frail individuals, unmet needs (compared to met needs) for formal care were associated to 18.8 percentage point increase in fall risk (95% CI, 0.1–37.6; $P = .049$), while unmet needs for informal care raised the risk by 22 percentage points (95% CI, 0.1–45.1; $P = .049$). No significant associations were found among non-frail individuals. Effects were particularly pronounced among women, those living alone, and adults aged 70+. Unmet care needs significantly increase the risk of falls among frail older adults. Targeted public health strategies are essential to prevent falls, preserve autonomy, and limit long-term care burdens in the frail population.

► **Hospice Enrollments From The Emergency Department Feature Short Admissions And High-Acuity Hospice Care**

KNIGHT, H. P., *et al.*

2026

Health Affairs 45(6): 700-707.

<https://doi.org/10.1377/hlthaff.2025.01218>

Medicare beneficiaries frequently visit the emergency department (ED) at the end of life, but little is known about the epidemiology of patients admitted to hospice from the ED. We used 100 percent Medicare fee-for-service claims from the period 2018–20 to describe the frequency of direct ED-to-hospice enrollments, associated patient and hospice agency characteristics, and patient outcomes. In this sample, 4.3 percent of initial enrollments in hospice originated from the ED. ED-to-hospice admissions featured short lengths-of-stay (21.7 percent were two days or less) and high rates of general inpatient level of care at the time of enrollment (23.6 percent). The 10 percent of hospice agencies with the highest proportion of ED-to-hospice enrollments were less often for-profit than agencies ranked below the fiftieth percentile in respect to proportion of ED-to-hospice enrollments. Further research is needed to increase understanding of how much patients benefit from ED-to-hospice transfers when their hospice stays before death are very short, and what drivers lead to these ED-to-hospice transfers.

► **Coût de la prise en charge des personnes atteintes de démence et résidant en institution en France : une comparaison EHPAD vs. Village Alzheimer**

KRIER, D.

2025

Journal de Gestion et d'Economie de la Santé 3(3): 3-26.

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Contexte : Le Village Landais Alzheimer Henri Emmanuelli (VLAHE), un modèle émergent pour la prise en charge des personnes atteintes de la maladie d'Alzheimer et de troubles apparentés, pourrait constituer une alternative ou une offre complémentaire aux EHPAD traditionnels. Cette étude compare le coût du VLAHE à celui des EHPAD pour les personnes atteintes de démence. Méthode : Le coût du VLAHE a été calculé selon la même méthodologie que celle de l'étude nationale des coûts EHPAD réalisée par l'Agence Technique de l'Information sur l'Hospitalisation (ATIH) en France. Les données financières et d'activités ont été recueillies auprès de l'administration du VLAHE, tandis que les coûts des EHPAD traditionnels ont été estimés par simulation à partir des résultats de l'étude nationale des coûts de l'ATIH. Résultats : Le coût total journalier par résident atteint de démence, hors charges liées à l'activité immobilière (loyer, crédit-bail, amortissement, etc.), s'élève à 184 € dans le VLAHE, contre 130 € en EHPAD traditionnel. L'analyse montre un ratio de personnel plus élevé dans le modèle Village ainsi qu'une redéfinition des missions des soignants, avec le rôle de « maîtresse de maison ». Conclusion : Cette étude fournit des estimations des coûts journaliers de prise en charge en institution des personnes âgées atteintes de démence en France, contribuant aux futures analyses médico-économiques du modèle Village Alzheimer. Des recherches supplémentaires sont nécessaires pour approfondir l'évaluation de son coût global et mesurer ses effets sur la santé et la qualité de vie des résidents.

► **Horizontal inequity in long-term care access under universal coverage in Japan (2001–2022)**

PING, R., *et al.*

2026

Health Policy 171: 105653.

<https://doi.org/10.1016/j.healthpol.2026.105653>

Background Japan has achieved universal public cov-

erage of long-term care (LTC) through a mandatory LTC insurance system established in 2000. However, evidence remains limited on whether this system ensures equal access to care based on needs, regardless of the ability to pay. Objective To examine income-related horizontal inequities in LTC utilisation in Japan and assess how equity patterns evolved across care types between 2001 and 2022. Methods We used nationally representative repeated cross-sectional data on community-dwelling individuals aged 40 and older who were certified LTC insurance beneficiaries from 2001 to 2022 (39,743 observations). Horizontal inequities in LTC utilisation were measured using corrected concentration indices, adjusted for care needs. Results After adjusting for care needs, formal care in the early years of LTC insurance, particularly home-visit services, was more concentrated among lower-income individuals, while informal care, mixed care, and short-term stays were more concentrated among higher-income individuals. Over time, inequities in care arrangements and most formal services moved closer to equity and were not reversed by later copayment increases for higher-income users. Unmet care needs were low in prevalence and largely equitably distributed. Need-adjusted time spent by primary caregiver was more concentrated among lower-income individuals. Conclusion The findings suggest that Japan's means-tested copayment system, together with caps on out-of-pocket payments, has not impeded equitable access to LTC services for lower-income users. However, inequities persist for services involving additional user charges. Policymaking should also consider household composition and caregiving norms that influence care composition across socioeconomic groups and strengthen targeted caregiver support.

► **Therapy Staff Turnover in Skilled Nursing Facilities: Facility Characteristics and Associations With Resident Outcomes**

PRUSYNSKI, R. A., *et al.*

2026

Med Care Res Rev 83(4): 251-260.

<https://doi.org/10.1177/10775587261433353>

This study measured turnover of physical, occupational, and speech therapy staff in skilled nursing facilities (SNFs) from July 2020 through September 2023. We estimated associations between SNF characteristics and high therapy staff turnover and between turnover and therapy-relevant SNF-level patient outcomes. Average quarterly turnover of combined therapy staff

was 13.0%, with higher turnover in for-profit SNFs, urban SNFs, and SNFs with lower therapy and nurse staffing and recent ownership changes. Periods of high therapy staff turnover within SNFs were associated with small increases in two adverse outcomes for long-term care residents: increasing need for assistance with activities of daily living and worsening ability to move independently. There was no association between turnover and falls for long-term residents or functional improvement for short-stay patients. Results suggest urban and for-profit SNFs could be targeted in efforts to reduce therapy staff turnover, with the potential for modest improvement in patient outcomes.

► **Contester les rapports d'âge pour les transformer. Quand des professionnelles de la vieillesse politisent leur travail au cours des années 1970**

RENNES, J.

2025

Sociétés contemporaines 139(3): 5-42.

<https://doi.org/10.3917/soco.139.0005>

Focalisés sur la jeunesse comme force révolutionnaire, les mouvements contestataires post-68 ont-ils ignoré les vieilles et les vieux ? À partir d'une démarche d'histoire orale confrontée à des archives professionnelles et militantes, cet article porte sur des formes méconnues de politisation de la vieillesse au cours des années 1970. En se focalisant sur un centre social et socioculturel expérimental parisien, Le Tournesol (1970-1976) et sur la revue forgée dans son sillage, Mathusalem, le Journal qui n'a pas peur des vieux (1976-1979), l'article analyse la mise en œuvre des dénonciations de la ségrégation, de l'infériorisation et de la dépossession des personnes âgées que l'on retrouve à la même époque au sein de la littérature critique sur le statut social de la vieillesse. Ce cas est appréhendé comme un analyseur de la réflexivité politique qui traverse alors le secteur professionnel du troisième âge, à l'instar du champ éducatif, médical ou judiciaire. Il constitue aussi un vecteur pour penser les tensions qui traversent durablement les mobilisations professionnelles et militantes visant à « libérer » les vieilles et les vieux, sans émaner directement des individus faisant l'expérience de la vieillesse.

► **Health dynamics and reporting bias at retirement: An analysis using high-frequency data**

WEN, J., *et al.*

2026

Journal of Health Economics 108: 103151.

<https://doi.org/10.1016/j.jhealeco.2026.103151>

We introduce a novel approach to identify state-dependent reporting bias in subjective health measures. The central idea is that health operates as a stock, making abrupt shifts in self-reported health (SRH) following retirement more likely to reflect reporting bias than actual changes. To capture such shifts, our analysis integrates three key elements: (1) differentiating stock and flow outcomes based on classical health theory; (2) leveraging an identification strategy inspired by regression discontinuity design; and (3) exploiting a unique high-frequency dataset on monthly health and retirement. Traditional estimates find a decline in SRH after retirement over longer periods; however, this decline steadily diminishes as the observation window narrows, showing no evidence of state-dependent reporting bias. Our analysis of short-term health dynamics also emphasizes distinguishing stock and flow health outcomes in policy evaluations.

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