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

Veille scientifique
en économie de la santé

Watch on Health Economics Literature

Décembre 2025 / December 2025

Assurance maladie	*Health Insurance*
E-Santé – Technologies médicales	*E-health – Medical Technologies*
Économie de la santé	*Health Economics*
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Géographie de la santé	*Geography of Health*
Handicap	*Disability*
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Systèmes de santé	*Health Systems*
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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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Produced by the IRDES Information Centre, this publication presents each month a theme-sorted selection of recently published peer-reviewed journal articles, grey literature, books and reports related to Health Policy, Health Systems and Health Economics.

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

Veille scientifique en économie de la santé

Watch on Health Economics Literature

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Assurance maladie

Health Insurance

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

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

2025

Health Services Research 60(5): e14646.

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

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

▶ Classifying the Integration of Healthcare Providers and Insurers

LIANG, X. ET MULLAHY, J.

2025

Health Economics 34(11): 1971-1976.

https://doi.org/10.1002/hec.70019

ABSTRACT The value-based payment reform prompted by the Affordable Care Act has stimulated vertical integrations of healthcare providers and insurers. The consequences of these integrations may vary significantly depending on the markets and entities involved. This article points out the limitations of familiar binary classifications for provider-insurer integrations in prior studies. To address these limitations, we propose a framework and taxonomy that include four key aspects for examining variations in provider-insurer integrations. The first is from the care delivery perspective; it sheds light on levels of care services owned by an integrated system and their variation across regions within the system. The second is from the insurance markets' perspective; it pertains to insurance markets in which an integrated system competes. The third is from the organizational perspective; it points out that whether the insurer or the provider is dominant in an integrated system may affect the system's priorities—care delivery reform or cost containment. The last highlights the dynamics of integrated systems that can involve the other three. We offer these insights and their possible applications hoping to sharpen discussion and research on provider-insurer integrations, and to assist antitrust agencies in evaluating relevant legal cases under the 2023 Merger Guidelines.

▶ Algorithmic decision-making in health care: Evidence from post-acute care in Medicare Advantage

MARR, J.

2025

Journal of Health Economics 104: 103055.
https://doi.org/10.1016/j.jhealeco.2025.103055

Health insurers use predictive algorithms to determine the necessary level of care and deny services they deem unnecessary. Using a difference-in-differences design, I study the partnership of a large Medicare Advantage insurer with a firm that uses a predictive algorithm to aid post-acute care coverage decisions. This partnership led to an immediate and sustained 13 percent decline in the length of skilled nursing facility stays. This effect was partially driven by large declines in longer skilled nursing facility stays (over 30 days). Despite reductions in health care use, I don't observe changes in health outcomes following the adoption of the predictive algorithm.

▸ The role of private equity funds in healthcare: trends, impact and policy responses

RECHEL, B., TILLE, F., MERCILLE, J., *et al.*
2025
Health Policy 161: 105439.
https://doi.org/10.1016/j.healthpol.2025.105439

E-santé

E-Health

▸ Des données de santé ouvertes ? L'entrepreneuriat numérique à l'épreuve des dynamiques institutionnelles du système de santé français (2004-2016)

BÉRUT, C.
2025
Gouvernement et action publique 14(2): 5-30.
https://doi.org/10.3917/gap.252.0005

Grâce à son système de remboursement des soins, la France dispose de bases de données de santé particulièrement riches. Protégées en raison de leur sensibilité, ces données ont néanmoins fait l'objet de politiques d'ouverture successives, qui ont favorisé tour à tour différents acteurs publics et privés. Alors que le mouvement open data promeut une ouverture des données croissante et indifférenciée, cet article interroge les dynamiques politiques ayant, au contraire, conduit à une ouverture à géométrie variable de ces données. Il s'appuie sur des entretiens semi-directifs et une analyse documentaire dans le cadre d'une étude qualitative et comparative de deux réformes majeures de l'accès aux données de santé : la loi du 13 août 2004 relative à l'Assurance maladie et la loi de modernisation du système de santé de 2016. Si le rôle des entrepreneurs du numérique apparaît marginal, les luttes institutionnelles propres au système de santé s'avèrent déterminantes dans l'explication du changement. L'article invite ainsi à repenser les relations entre secteur numérique et action publique sectorielle, et interroge plus largement le rôle des entrepreneurs de politique publique dans des contextes institutionnels fortement structurés.

▸ Implementation of the European Health Data Space: a qualitative study with health data experts from 23 countries

CERVERA DE LA CRUZ, P., LALOVA-SPINKS, T. ET SHABANI, M.
2025
Health Policy 161: 105428.
https://doi.org/10.1016/j.healthpol.2025.105428

Background As the formal adoption of the European Health Data Space (EHDS) draws nearer, questions surrounding the implementation of rules for the secondary use of health data abound. Objectives This study aims to explore the expectations of health data experts regarding the implementation of the EHDS. Methods To gain insights, we conducted semi-structured interviews with participants from 23 European countries. Data were analysed using inductive content analysis to identify key themes. Results Our findings reveal that the EHDS addresses some of the existing challenges for secondary health data use by setting clear rules for health data reuse and introducing new opportunities, such as enhanced competitiveness and cross-border data sharing. However, the implementation of the EHDS also brings about new challenges, including uneven interpretation across Member States, interaction with existing regulations, increased fees for accessing health data and heightened risks of data misrepresentation. These issues highlight the complexity of aligning diverse healthcare systems under a unified framework. Conclusions Significant investments are necessary to address the heterogeneity of health data and digital health systems across the Union. Additionally, incentives are essential to ensure the active engagement of all stakeholders, especially where systems for health data sharing and reuse are already in place.

▶ Piloting an infrastructure for the secondary use of health data: learnings from the HealthData@EU Pilot

CHRISTIANSEN, C. F., DOUPI, P., SCHUTTE, N., *et al.*

2025

European Journal of Public Health 35(Supplement3): iii3-iii4.

https://doi.org/10.1093/eurpub/ckaf073

▶ Anticipating ethical and social dimensions of the European Health Data Space: A rapid systematic review

DONIA, J. ET MARELLI, L.

2025

Health Policy 162: 105443.

https://doi.org/10.1016/j.healthpol.2025.105443

Background The European Health Data Space Regulation (EHDS) establishes a common governance framework intended to promote the use of health data for clinical care, research, innovation, and policymaking. Academic literature has increasingly focused on anticipating the social and ethical dimensions of the EHDS, but to date, no contributions have systematically reviewed these for their policy relevance. Objectives: This study set out to (a) identify ethical and social issues associated with the EHDS in the multi-disciplinary research literature, and (b) articulate policy recommendations. Methods: A rapid review of the research literature was performed. Results: Seven overarching topics were identified. Most issues relate to secondary use of health data, with disproportionate impacts on member states already facing digitalization challenges. Discussion: We suggest that responsible governance hinges on recognition of different and at-times competing goals, interests, and requirements. A fair, just, or equitable EHDS cannot be understood strictly in terms of fair outcomes in data use, but also requires grappling with contested notions of value. Conclusion: The EHDS's broader geopolitical significance should be emphasized. This especially includes attending to how local and regional socio-economic goals impact on what comes to be recognized as a priority in data-intensive health systems.

▶ Creating a data processing warehouse to support performance monitoring of cancer screening programmes in Europe using a common set of indicators

LUCAS, E., DIMITROVA, N., TOMATIS, M., *et al.*

2025

European Journal of Public Health 35(5): 977-983.

https://doi.org/10.1093/eurpub/ckaf119

The CanScreen-ECIS project implemented by International Agency for Research on Cancer aimed to define indicators to monitor, breast, cervical, colorectal, and lung cancer screening and create a validated mechanism for the European screening programmes to be able to systematically collect and submit performance data for public dissemination through European Cancer Information System (ECIS). Indicators were developed through a stepwise process of literature review, Delphi survey followed by face-to-face interaction. A survey questionnaire to report policies, protocols, and organization of screening programmes and a data collection tool to estimate indicators across the screening continuum were designed. These were integrated into a data warehouse to permit programme managers to access the tools, undergo training, submit data, and estimate the indicators. The same warehouse would allow peer-reviewing of submitted information and data and will ultimately be connected to ECIS for data visualization. Functionalities of the tools and the warehouse were pilot tested through data collection from several European countries. Total 23 indicators were selected based on priority and feasibility. Programme managers from 23 European countries completed the surveys and submitted data from national/regional screening programmes. Data to estimate the indicators were obtained from 17, 13, and 15 breast, cervical, and colorectal cancer screening programmes, respectively. Major challenges identified by the participants included collecting data from opportunistic screening and data disaggregated by socio-economic status and other indicators of inequalities. The data warehouse will facilitate systematic data collection to report the status and performance of cancer screening programmes in the EU.

User journeys in cross-European secondary use of health data: insights ahead of the European Health Data Space

FORSTER, R. B., ALVAREZ, E. G., ZUCCO, A. G., *et al.*

2025

European Journal of Public Health 35(Supplement3): iii18-iii24.

https://doi.org/10.1093/eurpub/ckaf096

The European Health Data Space (EHDS) regulation aims to facilitate cross-border sharing of health data across Europe. However, practical challenges related to data access, interoperability, quality, and interpretive competence remain, particularly when working with health systems across countries. This study aimed to evaluate and report the user journey of researchers accessing and utilizing health data across four European countries for secondary research purposes prior to implementation of EHDS. We conducted a narrative reflection of individual and collective experiences on key aspects of the user journey—discovery, access, use, and finalization. Data were gathered from various structured and unstructured sources, including an online log, prospective questionnaires, regular meetings, and interviews. Researchers faced challenges at different steps of the user journey, which included lack of data quality in national metadata catalogues (discovery stage). Differences in national regulations led to inconsistent timelines for gaining access to data (access stage), with approval times ranging from a few months to over a year. At the use stage, researchers experienced challenges in harmonizing health data due to variations in coding practices and data quality. Issues related to computational capacity caused further delays. Substantial challenges must be addressed for EHDS to succeed. Establishing knowledge hubs, fostering collaborations, and streamlining access processes are essential. Close collaboration with experts will likely be essential for an effective user journey. This analysis underscores the importance of collaboration, analytical reproducibility, and clear documentation to ensure the success and timely delivery of cross-border projects.

Telehealth Use by Home Health Agencies Before, During, and After COVID-19

MUKAMEL, D. B., SALIBA, D., LADD, H., *et al.*

2025

Health Serv Res 60(5): e14645.

https://doi.org/10.1111/1475-6773.14645

OBJECTIVE: To examine telehealth adoption and discontinuation by home health agencies (HHAs) during the COVID-19 pandemic in the context of telehealth pre-pandemic diffusion into the industry and its continued use once the pandemic abated. STUDY SETTING AND DESIGN: HHAs nationally, serving the most patients with dementia (averaging 33% of the agency's patients) were surveyed during October 2023 to November 2024. Key variables included the agency's adoption and discontinuation of specific telehealth technologies by year, the reasons for discontinuation, and the reasons for not adopting any telehealth technology, either before or during the pandemic. DATA SOURCES AND ANALYTIC SAMPLE: Data were collected via a web-based survey with telephone follow-ups. We received 791 responses (37% response-rate) and provide descriptive statistics of responses and graphics. PRINCIPAL FINDINGS: By 2019, prior to COVID-19, 183 (23%) of HHAs used telehealth, increasing to 446 (56%) by 2021. Growth occurred mainly in virtual visits. Of those HHAs adopting telehealth, 96 (19%) discontinued use later in the pandemic. Key concerns were about the appropriateness of the patient population and reimbursement. CONCLUSIONS: Patterns of adoption and discontinuation suggest that COVID-19 interrupted the innovation diffusion process of telehealth into home health. Telehealth's future will depend on information about cost-effectiveness and Medicare reimbursement policies.

Unleashing the potential of health data: from vision to reality in the HealthData@EU Pilot Project

RAFFAELLI, F., DORAZIL, M., BERNAUX, M., *et al.*

2025

European Journal of Public Health 35(Supplement3): iii1-iii2.

https://doi.org/10.1093/eurpub/ckaf003

Emotions Associated with Teleconsultation: An Analysis of Users' Messages on X (Twitter) in Chile

RAMÍREZ-CORREA, P., RONDÁN-CATALUÑA, F. J. ET ARENAS-GAITÁN, J.

2025

Health Policy 162: 105449.

https://doi.org/10.1016/j.healthpol.2025.105449

Background Digital healthcare transformation requires incorporating patient perspectives. Increasingly proactive citizens utilize teleconsultation, fostering doctor–patient–technology integration that enhances system efficiency, service quality, and sustainable healthcare management. Objective This study focuses on exploring perceptions of satisfaction related to teleconsultation, using emotions detected on X (Twitter) as a reference. Methods First, an analysis of the predominant emotions in the posts (tweets) of users belonging to the three main metropolitan areas is carried out. Then, using one type of structural equation modelling that is Partial Least Square (PLS-SEM), we identify the emotions that have the most significant influence on the variability of satisfaction, taking into account geographical differences. Results The results highlight trust as the most relevant emotion to explain the variation in satisfaction and reveal statistically significant differences between the different areas analysed. A considerable proportion of the population is not satisfied with this mode of healthcare provision. Conclusions This study highlights key factors influencing the integration of teleconsultation into healthcare systems. Patient perspectives and emotional responses—particularly trust, anticipation, fear, and sadness—are critical for successful implementation. Findings reveal regional disparities in satisfaction, with more developed areas providing superior teleconsultation experiences, likely due to stronger infrastructure and resources. Moreover, variations were identified in how emotions affect satisfaction across regions, underscoring the need for context-specific approaches. Strategies that enhance trust and mitigate fear in less developed regions appear essential. These insights emphasize the importance of aligning digital healthcare initiatives with patient-centered, regionally tailored management practices.

▶ Digitalization of Access to Primary Care: Is There an Equity-Efficiency Trade-Off?

RODRIGUES, D., KREIF, N., DARZI, A., *et al.*

2025

Health Economics 34(10): 1943-1962.

https://doi.org/10.1002/hec.70014

ABSTRACT In the English National Health Service, most patients can use an online platform to send a written request to the practice, in addition to calling or visiting the practice in person. However, there are concerns that the availability of an online access route to primary care can adversely impact healthcare provision for older or lower socioeconomic groups. To examine those concerns, we explore the differential timing of online platforms' implementation between 2019 and 2020 across 289 practices covering over 2.5 million patients in North West London. We find no evidence of an impact of the online access route on age and socioeconomic-related inequity in synchronous interactions in primary care, but observe an increase in all interactions in this setting and in some cases, a small reduction (worst case, no changes) in unplanned hospital care. These findings suggest that having an online access route to primary care can improve the provision of healthcare services, at no detriment to patients from older and lower socioeconomic groups.

▶ The use of discrete choice experiments in evaluating telehealth: a systematic review

SAVIRA, F., FRITH, M., NGUYEN, D., *et al.*

2025

Health Policy 161: 105421.

https://doi.org/10.1016/j.healthpol.2025.105421

Background There is a growing body of evidence from discrete choice experiments related to telehealth. Discrete choice experiments offer valuable insights in informing the design and evaluation of telehealth services and supporting the telehealth implementation and policy. Objective This review aims to examine studies assessing consumer preferences for telehealth using discrete choice experiments. Methods A systematic review was conducted, searching five health and multidisciplinary databases from inception until 4 April 2024. Grey literature searches, hand-searching, and reference list checks were also performed. Results Of 2,832 studies screened, 52 met the inclusion criteria. Most studies were conducted from the patient perspective (n=47/52, 90%) and covered a wide range of populations and settings. Of the included studies eligible for quality assessment, 68% (n=23/34) received high-quality ratings, while others were assessed as moderate. Studies comparing face-to-face consultations with telehealth generally found a preference for face-to-face appointments. Telehealth is viewed more favourably if it can be offered at a lower cost, reduces wait times, and is part of a comprehensive care plan. Telehealth tends to be preferred by younger patients and clinicians, those digitally literate, and those with less severe or more private and stigmatised health conditions. Conclusion While face-to-face consultations are generally preferred, telehealth is viewed as advantageous if it reduces costs, shortens wait times, and is integrated into comprehensive care. The findings highlight the importance of considering these attributes when designing telehealth preference studies and informing the adoption and design of telehealth services.

▶ Shaping the future EHDS: recommendations for implementation of Health Data Access Bodies in the HealthData@EU infrastructure for secondary use of electronic health data

SVINGEL, L. S., JENSEN, C. E., KJELDSEN, G. F., *et al.*

2025

European Journal of Public Health 35(Supplement3): iii32-iii38.

https://doi.org/10.1093/eurpub/ckaf033

European Union (EU) Member States face challenges in using health data for secondary purposes, constrained by inconsistent digital health systems and limited cross-border sharing. One aim of the European Health Data Space (EHDS) is to facilitate secondary health data use through the HealthData@EU infrastructure and Health Data Access Bodies (HDABs). This article provides recommendations essential for HDAB implementation, informed by the HealthData@EU Pilot project. From October 2022 to December 2024, Work Package 4 gathered insights from the HealthData@EU Pilot project, including from technical work packages and use cases, and complementary insights from the members of the HDABs Community of Practice and the External Advisory Board. Data collection involved workshops, interviews, and questionnaires, with thematic analysis guided by the EHDS user journey and the World Health Organization's National eHealth Strategy Toolkit. Recommendations cover infrastructure, services, and interoperability. Each Member State should designate HDABs to manage secondary health data use and facilitate cross-border access. National infrastructure components deployed by HDABs and National Contact Points and a metadata catalogue compliant with the newly developed HealthDCAT-AP specification are advised to support data discovery, with a common data access application form to streamline the data permit application process. Harmonized validation procedures are recommended for ensuring high data quality and semantic interoperability. Implementation of HDABs within the HealthData@EU infrastructure represents an important step towards accessible health data for secondary use across the EU. Effective implementation requires collaboration at both national and EU level, addressing remaining ambiguities for HDAB functionality within the EHDS framework.

▶ Feasibility of mapping cross-country population coronavirus disease 2019 metrics in a federated design: learnings from a HealthData@EU Pilot use case

VANDE CATSYNE, C. A., SLOT, M., BUBLE, T., *et al.*

2025

European Journal of Public Health 35(Supplement3): iii11-iii17.

https://doi.org/10.1093/eurpub/ckaf017

The European Health Data Space aims to transform health data management across the EU, supporting both primary and secondary uses of health data while ensuring trust through General Data Protection Regulation compliance. As part of the HealthData@EU Pilot, this study investigates coronavirus disease 2019 (COVID-19) testing, vaccination, and hospitalization metrics across six European countries, with a focus on socioeconomic disparities and challenges in cross-border data access and standardization. This observational, retrospective cohort study used a federated analysis framework across Belgium, Croatia, Denmark, Finland, and France. Data were linked from administrative, social, health, and care records within each country's trusted research environment. A Common Data Model (CDM)-guided data harmonization, enabling nodes to perform independent analyses and share aggregated results. Key data processes (discovery, access, preparation, and analysis) were decentralized, with significant variability in data access procedures, security protocols, and available resources among nodes. The study revealed substantial differences in COVID-19 testing, vaccination, and hospitalization rates across countries. Denmark exhibited notably higher testing and infection rates. However, the study encountered key challenges: complex data access procedures, fragmented and incomplete socioeconomic data, and the need for extensive harmonization. Learnings from this pilot underscore the importance of streamlined, cross-country data access and standardization processes, which the European Health Data Space (EHDS) framework aims to address. The pilot demonstrates the feasibility of federated health data analysis across multiple countries while highlighting limitations in data access and interoperability. The EHDS framework offers a promising path to overcome these barriers, supporting efficient and standardized cross-border health research in the EU.

Économie de la santé

Health Economics

Fairness preferences over allocation of scarce medical resources

YANG, Z., MELKONYAN, T. ET SAFRA, Z.

2025

Social Science & Medicine 384: 118462.
https://doi.org/10.1016/j.socscimed.2025.118462

Many argue that randomization is a fair way to allocate scarce resources. However, little is known about individual justice preferences for these mechanisms. This gap is particularly consequential, as public choices are often influenced by individual justice preferences. To address it, we propose a model using proportional probability weights for recipients' claims and conduct an empirical analysis using a longitudinal survey on allocating medical resources between two patients of different ages. A three-year panel dataset was collected from 2020 to 2022, containing 301 representative respondents. Our results show strong support for randomization reflecting proportional claims: 17% of participants favored equal probabilities, 63% prioritized younger patients, and 20% favored older patients, indicating varied justice principles. The findings indicate that the use of weighted lotteries to allocate scarce medical resources—and scarce resources more broadly—is consistent with the public's tradeoff between considerations of justice and efficiency.

Les lois de financement de la Sécurité sociale, 30 ans après

LES TRIBUNES DE LA SANTÉ

2025

Les Tribunes de la santé 85(3) : 78p.
https://stm.cairn.info/revue-les-tribunes-de-la-sante-2025-3

Trois décennies donc après cette réforme majeure de la Sécurité sociale, Les Tribunes de la santé proposent à leurs lecteurs les réflexions d'acteurs ou d'analystes du système de santé sur les origines, les caractères et les conséquences du maelström qui a affecté l'organisation de la Sécurité sociale en France.

Baumol's cost disease in acute versus long-term care: Do the differences loom large?

CELEBI, K., HARTWIG, J. ET SANDQVIST, A. P.

2025

International Journal of Health Economics and Management 25(2): 159-191.
https://doi.org/10.1007/s10754-025-09392-9

Baumol's (Am Econ Rev 57: 415–426, 1967) model of 'unbalanced growth' yields a supply-side explanation for the 'cost explosion' in health care. Applying a testing strategy suggested by Hartwig (J Health Econ 27: 603–623, 2008), a sprawling literature affirms that the 'Baumol effect' has both a statistically and economically significant impact on health care expenditure growth. Skeptics maintain, however, that the proliferation of hi-tech medicine in acute care is clearly at odds with the assumption underlying Baumol's model that productivity-enhancing machinery and equipment is only installed in the 'progressive' (i.e. manufacturing) sector of the economy. They argue that Baumol's cost disease may affect long-term care, but not acute care. Our aim in this paper is to test whether Baumol's cost disease affects long-term care and acute care differently. Our testing strategy consists in combining Extreme Bounds Analysis (EBA) with an outlier-robust MM estimator. Using panel data for 23 OECD countries, our results provide robust and statistically significant evidence that expenditures on both acute care and long-term care are driven by Baumol's cost disease, even though the effect on long-term care expenditures is more pronounced.

L'évolution de la place de l'évaluation économique en santé en France

DE POUVOURVILLE, G.

2025

Med Sci (Paris) 41: 119-132.
https://doi.org/10.1051/medsci/2025125

Le système de financement des soins souffle ses 80 bougies. Un anniversaire sous tension et l'heure des grands choix !

FRANC, C.

2025

Med Sci (Paris) 41(HS): 133-137.

The Citizens' Distributional Preferences for Health Care Resource Allocations: The Non-Negligible Role of Option Value

HANSEN, L. D., KJÆR, T. ET GYRD-HANSEN, D.

2025

Health Economics 34(10): 1773-1781.

https://doi.org/10.1002/hec.70006

ABSTRACT The stated preference literature on equity in health aims to enhance our understanding of the public's preferences for allocation of health resources to promote fairness and justice in the distribution of healthcare. This paper explores how different elicitation approaches impact on the elicited distributional preferences in the context of health. We randomly allocated respondents to one of two elicitation approaches: the ex post social decision maker perspective and the private ex ante insurance perspective. Respondents were asked to make choices between healthcare resource allocation distributions that follow different priority rules regarding maximization and equality. We find that preferences differ across the two approaches with the health maximization objective receiving less support under the ex ante perspective. The contribution of this paper is to demonstrate that option value, in addition to inequality aversion, provides an important argument for average citizens' distributional preferences, and that both sets of preferences may represent important inputs to policy making.

Global paid and unpaid productivity losses due to cancer-related mortality

KONG, Y. C., NIYIGABA, J., TRAN, P. B., *et al.*

2025

JNCI: Journal of the National Cancer Institute.

https://doi.org/10.1093/jnci/djaf193

Cancer is among the most important causes of premature deaths globally. We estimated the value of paid and unpaid productivity losses due to premature mortality in 2022 from all cancers worldwide. Years of productive life lost were derived from cancer mortality data for 36 cancer types among people of working age (15-64 years) in 185 countries for the year 2022. Paid productivity losses were estimated using the human capital approach, while unpaid activities were valued using the opportunity cost approach. Lost productivity was estimated using wages, workforce statistics, and time spent on unpaid activities from various sources. All analyses were performed by sex and age group for each country. In 2022, productivity losses from premature cancer mortality were valued at an estimated US$566 billion, equivalent to 0.6% of the global gross domestic product. Of the total value, 53.9% (US$305 billion) was attributable to paid productivity losses, and 46.1% (US$260 billion) to unpaid productivity losses. Paid productivity losses were generally higher among men, while unpaid productivity losses were greater among women, with variations seen across world regions. The total value of lost productivity was greatest for lung cancer, followed by breast and liver cancers. Per cancer death, testicular cancer, melanoma of the skin, and brain and nervous system cancer generated the highest value of productivity losses. The substantial value of productivity losses from premature cancer mortality highlights its marked societal burden. Continuous investments in global cancer control efforts, including in less common cancers, will yield substantial returns-on-investment to national economies, especially in transitioning countries.

Income and Health Care Consumption: Evidence From Mortgage Payment Shocks

LEE, H., BAEK, D. ET MASON, J. R.

2025

Health Economics 34(10): 1853-1868.

https://doi.org/10.1002/hec.70009

ABSTRACT During the Great Recession, monetary stimulus had asymmetric impacts on mortgages with different interest rate structures, leading to a significant and unexpected reduction in mortgage payments for adjustable-rate mortgage (ARM) borrowers, which in turn increased their disposable income. Leveraging this quasi-experimental setup, our analysis reveals that healthcare expenditures and medical service utilization increased in counties with a higher prevalence of ARMs. The heterogeneity between ARM and fixed-rate mortgage (FRM) borrowers, combined with the more pronounced economic decline observed in counties densely populated with ARMs, allows our study to provide conservative lower bound estimates of the effects of income shocks on household healthcare consumption.

Price-Shifting? Spillovers of Medicare Advantage Network Inclusion on Hospital Prices Paid by Commercial Insurers

MARR, J., POLSKY, D. ET MEISELBACH, M. K.

2025

Health Serv Res 60(5): e14640.

https://doi.org/10.1111/1475-6773.14640

OBJECTIVE: To compare inpatient hospital prices in the commercial insurance market between insurers that do and do not include hospitals in their Medicare Advantage (MA) networks. STUDY SETTING AND DESIGN: We compared inpatient negotiated commercial prices between insurers at the same hospital that do not include the hospital in their MA network and those that do. We used Poisson regression with hospital fixed effects, adjusting for insurer fixed effects and insurer-market covariates. DATA SOURCES AND ANALYTIC SAMPLE: Using data from Turquoise Health, the American Hospital Association survey, and Clarivate DRG, we identified 5654 insurer-hospital pairs for seven large insurers that participate in both the commercial and MA markets. PRINCIPAL FINDINGS: Insurers pay 4.7% higher commercial prices for major joint replacements when the hospital is in their MA network (95% confidence interval: 2.0, 7.5%). The average adjusted negotiated commercial price in our sample was $28,889.91 when the insurer did not have the hospital in its MA network but $30,249.16 when it did. We find similar magnitudes for the four other «shoppable service» diagnosis related groups commonly reported in the transparency data. CONCLUSION: On average, insurers pay higher commercial prices to hospitals that are in their MA network.

Commercial Insurers Paid More For Procedures At Hospital Outpatient Departments Than At Ambulatory Surgical Centers

MAUGHAN, M. P., RYAN, A. M., WHALEY, C. M., *et al.*

2025

Health Affairs 44(10): 1291-1297.

https://doi.org/10.1377/hlthaff.2025.00297

Site neutrality in payment practices has become a salient issue in the US health care debate, as rising prices have brought increased pressure for policy action. Although Medicare has received disproportionate attention, these policies could also apply to commercial insurers, particularly to address payment differentials between hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs). Using 2024 Transparency in Coverage data provided by Clarify Health on commercial prices for three insurers (UnitedHealthcare, Cigna, and BlueCross BlueShield), we compared payments for thirteen common procedures across settings. Overall, in 2024, commercial prices were $1,489 (78 percent) higher in HOPDs than in ASCs, whereas Medicare prices were $633 (97 percent) higher. However, site payment differentials varied substantially across payers: Cigna had the lowest differentials between HOPDs and ASCs ($327), whereas United had the highest ($1,673). Cigna achieved this through provider selection, contracting with only 14 percent of HOPDs in applicable markets compared with an average of 76 percent for United and BlueCross BlueShield. If United and BlueCross BlueShield paid Cigna's average HOPD rates for these procedures, together they would save approximately $1.4 billion a year. Our results suggest that payers can reduce site differentials through provider selection; they also imply that larger insurers with broader networks may continue to reimburse different sites differently in the absence of either government action or a shift in market dynamics.

A Simple Measure of Catastrophic Health Expenditures

OGWANG, T. ET MWABU, G.

2025

Health Economics 34(10): 1821-1831.

https://doi.org/10.1002/hec.70007

ABSTRACT In this paper, we propose a simple Watts-type measure of catastrophic health expenditure (CHE) which is an adaptation of the classic Watts poverty measure. The appeal of the proposed measure stems from the fact that it is both additively decomposable (i.e., it provides information on the contributions of the various population subgroups of interest, e.g., as categorized by gender, race, region, etc., to the overall level of CHE), and multiplicatively decomposable (i.e., it enables identification of three key drivers of CHE, namely, CHE incidence, CHE intensity and CHE inequality). We also describe how the Watts-type CHE measure can be estimated and additively decomposed using the widely available ordinary least squares regression packages. The empirical example provided shows the policy value of the Watts-type CHE measure, which makes it a useful supplement to the Foster-Greer-Thorbecke type measures of CHE recently proposed by Ogwang and Mwabu. Temporal dynamics in the Watts-type CHE measures are also introduced.

Guiding Health Resource Allocation: Using Population Net Health Benefit to Align Disease Burden with Cost Effectiveness for Informed Decision Making

RAO, M., WALKER, S., CLAXTON, K., *et al.*

2025

Applied Health Economics and Health Policy 23(5): 759-766.

https://doi.org/10.1007/s40258-025-00964-x

Limited healthcare resources necessitate a strategic approach to their allocation. This paper highlights the importance of population net health benefit (NHB) metric as a means of aligning two existing concepts used for resource prioritization in health: burden of disease and cost effectiveness. By explicitly incorporating health opportunity costs and eligible patient population size, NHB provides a clearer understanding of the likely scale of impact of interventions on population health. Moreover, when expressed in disability-adjusted life years (DALYs) averted, NHB enables policymakers to effectively communicate the population-level health gains from interventions relative to the existing disease burden. Using a stylized example, we demonstrate the estimation of population NHB for four alternative health interventions and its use in resource allocation decisions. The analysis reveals how variations in patient population size and health opportunity costs can significantly impact NHB estimates, ultimately influencing resource allocation decisions. The results further illustrate how NHB can be expressed as a proportion of the total disease burden, allowing for the consideration of the percentage of the overall burden addressed by each intervention. The paper demonstrates how population NHB combines cost effectiveness with components of disease burden, offering a more comprehensive approach to health intervention selection and implementation. As countries move towards universal health coverage, this metric can aid policymakers in making informed, evidence-based decisions.

Is Health Financing Fair? Evidence from 29 Countries on the Progressivity of Health Care Revenue Collection

RICE, T., WAITZBERG, R. ET VÕRK, A.

2025

Health Policy 161: 105429.

https://doi.org/10.1016/j.healthpol.2025.105429

Impact socioéconomique des troubles du neurodéveloppement en France

SCHOENTGEN, B., CHATIN, E., SALLÉ, H., *et al.*

2025

L'Encéphale 51(5): 557-562.

https://doi.org/10.1016/j.encep.2024.11.015

Résumé Introduction Cet article résume un travail d'évaluation des impacts économiques liés aux retards de diagnostic et de suivi des troubles neurodéveloppementaux en France, qui concernent 2 à 3 millions de Français. Méthode L'étude a été réalisée avec le soutien d'Ashoka France, dans le cadre d'une collaboration entre Goodwill-management et l'Association Aloïs. Goodwill-management, cabinet spécialisé dans l'accompagnement des organisations de l'économie sociale et solidaire, propose chaque année un soutien pro bono pour l'évaluation de l'impact social. En 2022, il sélectionne le projet de l'Association Aloïs, centre d'expertise clinique et recherche sur les troubles cognitifs à tous les âges de la vie. Une revue de la littérature, la collecte de données publiques ainsi qu'une analyse économique approfondie ont permis d'identifier les coûts et les leviers d'économie potentiels. Résultats En France, ces troubles coûtent environ 28 milliards d'euros par an. Conclusion Les conséquences économiques majeures sont notamment dues aux diagnostics tardifs, la variabilité des prises en charge et l'impact sur la vie professionnelle des principaux concernés et leurs aidants. En vue de réduire les coûts sociétaux et améliorer la qualité de vie des personnes touchées, les recommandations proposées insistent sur l'importance de diagnostiquer ces troubles tôt, rendre plus accessible les modes de prises en charge recommandées par la Haute Autorité de santé (HAS), ainsi que favoriser des interventions ciblées de prévention et de psychoéducation au sein des entreprises, sur l'accompagnement des salariés souffrant de ces troubles mais aussi des salariés aidants. La mise en œuvre de ces mesures pourrait générer des économies importantes tout en soutenant les personnes affectées.

Environnement et santé

Environmental Health

Priority Setting in the Context of Planetary healthcare

APANTAKU, G. O., KAPIRIRI, L., NORHEIM, O. F., *et al.*

2025

Applied Health Economics and Health Policy 23(6): 935-945.

https://doi.org/10.1007/s40258-025-00980-x

The realities of ecosystem breakdown and climate change pose a significant threat to the health of individuals around the world, disproportionately affecting poor and vulnerable populations. Every sector in society, including healthcare, needs to be engaged in the tremendous collective effort and transformational change needed to limit global warming. We see priority setting as having a key role to play in reallocating existing budgets within healthcare systems whilst at the same time being used to facilitate sustainable and more efficient resource allocation across countries. Priority setting looks to fairly distribute resources with the goal of improving patient and population health outcomes. However, these goals can be broadened to include consideration of environmental impact based on our understanding of the necessity of emissions reduction to address the climate crisis and promote population health. In this paper, we introduce key concepts of priority setting and identify the interplay between priority setting and the realities of resource scarcity in the realm of planetary healthcare. We propose that applying priority-setting principles could serve at least three goals; (1) protect and improve health outcomes; (2) limit unnecessary and marginal care; and (3) facilitate a just transition to a sustainable healthcare system.

État de santé

Health Status

Healthcare pathways and social experiences of Lewy body dementia and Alzheimer's disease in Ireland

CONLON, J., KINCHIN, I. ET LEROI, I.

2025

Social Science & Medicine 383: 118510.

https://doi.org/10.1016/j.socscimed.2025.118510

Objective This study examines how social and healthcare structures in Ireland shape the experiences of individuals diagnosed with Lewy body dementia (LBD) and Alzheimer's disease (AD), with particular attention to diagnostic pathways, care access, and social constructions of dementia. Methods Twenty-three participants with mild to moderate dementia resulting from LBD (n = 12) and AD (n = 11) participated in in-depth interviews between September 2022 and February 2023. Using a descriptive phenomenological approach informed by social constructivist perspectives, interviews were analysed to understand how institutional, geographical, and social factors influence experiences of diagnosis, post-diagnostic support, and public awareness. Results Healthcare structures and social understanding of dementia created divergent experiences for individuals with LBD and AD. While AD participants generally encountered established diagnostic pathways aligned with dominant cultural understanding of dementia as memory loss, LBD participants faced structural barriers due to complex symptomatology and limited specialist knowledge. Geographic inequalities in accessing specialised diagnostic services particularly affected rural LBD participants. Post-diagnosis, LBD participants encountered greater institutional barriers in accessing appropriate support, reflecting systemic gaps in service provision. Both groups highlighted how societal misconceptions about dementia shaped their lived experiences, with LBD participants particularly affected by the cultural dominance of the Alzheimer's narrative. Conclusion This study demonstrates how social structures, healthcare systems, and cultural understandings of dementia create inequitable experiences for individuals with different forms of dementia in Ireland.

Findings highlight the need for structural changes in healthcare delivery, increased professional education about LBD, and broader societal awareness to address these disparities.

▶ The global, regional, and national burden of cancer, 1990-2023, with forecasts to 2050: a systematic analysis for the Global Burden of Disease Study 2023

FORCE, L. M., KOCARNIK, J. M., MAY, M. L., *et al.*

2025

The Lancet 406(10512): 1565-1586.

https://doi.org/10.1016/S0140-6736(25)01635-6

Background Cancer is a leading cause of death globally. Accurate cancer burden information is crucial for policy planning, but many countries do not have up-to-date cancer surveillance data. To inform global cancer-control efforts, we used the Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) 2023 framework to generate and analyse estimates of cancer burden for 47 cancer types or groupings by age, sex, and 204 countries and territories from 1990 to 2023, cancer burden attributable to selected risk factors from 1990 to 2023, and forecasted cancer burden up to 2050.

▶ COVID-19 pandemic's impact on French Health Students' consumption of substances – a mixed analysis of their substance use

ROLLAND, F., FRAJERMAN, A., FALISSARD, B., *et al.*

2025

L'Encéphale 51(5): 486-491.

https://doi.org/10.1016/j.encep.2024.10.003

Objectives The COVID-19 pandemic had a huge impact on global mental health. Health care students, both as young people and regarding their student condition, were a more at-risk population. During the first and the third waves, two national surveys already found high levels of psychological distress (21 to 83% of severe psychological distress). This nationwide study focused on health care student changes in substance or treatment use during the pandemic. Methods We did an online national cross-sectional study addressing all health care students in France from April 4 to May 11, 2021. The questionnaire included sociodemographic and work conditions questions, Kessler 6 scale, and simple questions about psychotropic treatments or substance use. Results We obtained 16,937 answers, including 54% nurses and 16% medical students. Increased psychoactive substance use (alcohol, tobacco and cannabis) was associated with males, older students, those having financial difficulties and using more psychotropic treatments. Nursing students were more at risk than others. Increased psychotropic treatment use (anxiolytics, hypnotics) was associated with being a woman, older, having financial difficulties, having high psychological distress, and using more psychoactive substances. Medical, pharmacy, dental and midwife students were more at risk than others. The response rate was low (5,6%), and nursing students represented more than half of the respondents. Conclusions Compared to our first national survey, substance use (21% versus 13%) and psychotropic treatment use (18% versus 7.3%) increased hugely. These results highlight the need to identify the specific causes of substance use by health care students to better support them. As future health professionals, this is a major public health issue.

Géographie de la santé

Geography of Health

▶ Tracing place and health over Time: Advancing longitudinal approaches in geospatial health applications

DESJARDINS, M. R. ET RINNE, T.

2025

Health & Place 95: 103527.

https://doi.org/10.1016/j.healthplace.2025.103527

Our special issue on "Longitudinal Analysis in Geospatial Health Applications" highlights major advances in understanding how dynamic environments shape health across the life course. Featuring innovative methods, including medical informatics, artificial intelligence, and precise residential history protocols, authors demonstrate how exposures, neighborhood opportunities, and social inequalities accumulate and interact over time and space. Studies span global contexts, documenting the health impacts of mobility, residential (dis)advantage, environmental hazards, built and food environments, and access to greenspace. Key findings reveal that persistent disadvantage, climate-driven or voluntary mobility, and environmental injustice all profoundly influence health trajectories. The COVID-19 pandemic further spotlighted and amplified spatial inequities in resource access and health behaviors. Collectively, the contributions call for integrated, longitudinal, and place-based public health strategies, emphasizing that effective interventions must consider both spatial and temporal dynamics. These works pave the way for building healthier, more equitable communities through sustained, data-driven, and context-aware action.

▶ Micromobilities: The Turn to Health, Social Interaction and Inclusivity

LOO, B. P. Y.

2025

Social Science & Medicine 385: 118602.

https://doi.org/10.1016/j.socscimed.2025.118602

Walking, cycling and other means of micromobility (encompassing lightweight and non-enclosed vehicles like scooters) share common characteristics of not relying on fossil fuels (zero- or low-carbon), non-enclosed (unprotected), and being slower than mechanized transport modes, such as private cars and trains. With less than five years remain for reviewing the 2030 Agenda for Sustainable Development, micromobilities have become more important. First, while traffic injury risk has been the single most important research focus, the much wider interface of slow mobility, environment and health is coming to the forefront. The interface ranges from the negative environmental exposure to health to the more positive environmental exposure to fresh air, greenery and blue assets. Second, micromobilies are important not only for accessibility but also people's desire for mobility, whereby people-to-people interaction and people-environment interaction naturally happen. Third, the special needs of the vulnerable groups in society have become eminent. The need to provide a connected walking, cycling and micromobility infrastructure suitable for use by children and older adults should be prioritized.

Handicap

Disability

▶ The Impact of Child Disability on Parental Outcomes: Evidence From Sweden

ASUMAN, D., GERDTHAM, U. G., ALRIKSSON-SCHMIDT, A. I., *et al.*

2025

Health Economics 34(11): 2004-2036.

https://doi.org/10.1002/hec.70017

ABSTRACT Parents of children with disabilities may face higher labor-market penalties given the extra care and support required. Using Swedish administrative data, we focus on first-born children with Cerebral Palsy (CP) to estimate impacts on parental labor-market outcomes. We apply an event study approach to identify effects up to 10 years after the birth of the child. Our results show that employment and earnings of mothers decrease in the short run and increase in the long run whereas for fathers, a marginal decrease is observed in the short run. The effects differ by severity of the disability, with mothers of children with severe impairments driving the increases in the long run, whilst mothers of children with mild impairments appear to experience a penalty. Further, transfers and benefits from the Swedish social insurance system compensate parents for some of the potential costs associated with caring for a child with CP.

▶ The Time Cost of a Disability

HAMERMESH, D. S. ET MYCK, M.

2025

Journal of Health Economics: 104 :103079.

https://doi.org/10.1016/j.jhealeco.2025.103079

ABSTRACT We consider how a physical disability alters patterns of time use. A disability may raise the time cost of some activities, making them differentially less worth doing; or it may make switching activities more costly. Both possibilities predict that fewer activities will be undertaken, with more time spent on each. These explanations describe our correlational findings based on non-working ATUS 2008-22 respondents ages 70+, 32 percent of whom self-assess a disability. Data from the 2013 Polish Time Use Survey, where disability is medically certified, show similar results and demonstrate the same loss of variety over multiple days. Remarkably similar basic results are found using homogenized British, Canadian, French, Italian, and Spanish time diaries. Evidence from a "sesqui-difference" test on the ATUS data hints that the relationship is causal. Overall, a mobility/physical disability leads an otherwise identical person to engage in over 10 percent fewer activities on a typical day. The lost variety represents extra costs equivalent in data from six countries to over twice the average annual income of older individuals.

Hôpital

Hospital

Le financement des hôpitaux publics. Approche conceptuelle en France : Du prix de journée à la tarification à l'activité

BERTRAND, D.

2025

Bulletin de l'Académie Nationale de Médecine 209(8): 1084-1089.

https://doi.org/10.1016/j.banm.2025.04.023

Résumé Le choix des modes de financement de l'hôpital, dans les systèmes de santé développés, est assumé par un tiers payeur, public ou privé en fonction de l'organisation de la protection sociale du pays. Depuis 1950, en France, plusieurs stratégies ont été proposées pour déterminer les ressources nécessaires à la prise en charge des patients hospitalisés. Trois mécanismes se sont suivis pour établir le budget hospitalier : le prix de journée, la dotation globale de financement et enfin la tarification à l'activité, avec deux caractéristiques que l'on a cherché à améliorer, d'une part, un financement prospectif et non rétrospectif, d'autre part, un niveau de connaissance des soins nécessaires pour une pathologie. Le premier a consisté en un forfait à la journée calculé sur les coûts totaux annuels de l'établissement divisés par le nombre de journées effectué pendant cette même année. Le second a consisté à utiliser le budget de l'année N en lui appliquant un taux directeur (pourcentage d'augmentation) pour obtenir le budget de l'année N+1. Le troisième est issu d'un mécanisme mis en place aux USA c'est à dire un système de classement des patients selon leurs besoins dans des groupes homogènes de malades ou iso-ressources : le financier sait ainsi ce qu'il rémunère. Une comparaison succincte avec le financement des hôpitaux privés à but, lucratif, ex-objectif quantifié national y est introduite. Mais le financement n'est qu'un élément participant à l'efficience du système de soins hospitaliers, la qualité des soins, la planification et le concours de la médecine ambulatoire de premier recours.

The Impact of Rural Hospital Closures and Mergers on Health System Ecologies: A Scoping Review

COATES, A., PROBST, J., SARWAL, K., *et al.*

2025

Medical Care Research and Review 82(5): 359-375.

https://doi.org/10.1177/10775587251355671

Despite playing a pivotal role in rural community health services delivery and in local economies, rural hospitals in the United States have closed or merged with larger health networks at alarming rates. This scoping review examines what is known about the impacts of rural hospital closures and mergers since 2010. Using the literature, we inductively derived a new Health System Ecologies Impact Matrix research tool to assess knowledge related to health system changes. Most of the included studies examined closures, primarily reporting on community impacts. Knowledge gaps remain related to financial-, workforce-, and utilization-related outcomes, and little is known about impacts on neighboring hospitals and communities. Few studies report effects of rural hospital mergers, primarily focusing on financial and utilization out-

comes for the merged hospital. No studies examined the impacts of rural hospital mergers on patients or individuals and their social environments.

L'évolution des dépenses hospitalières en France (2014–2023)

COLIN, C.

2025

Bulletin de l'Académie Nationale de Médecine 209(8): 1079-1083.

https://doi.org/10.1016/j.banm.2025.03.010

Résumé La France est le deuxième pays européen après l'Allemagne pour la part de son PIB consacrée à la santé (11,8 % en 2022). La Dépense Courante de Santé au sens international (DCSi) s'élève à 325 milliards d'euros, soit 4 600 euros par habitant en 2023. Depuis la tarification à l'activité, les dépenses hospitalières n'ont cessé de croître pour atteindre 122 milliards en 2023. Cette progression des dépenses hospitalières est très corrélée à l'ensemble des dépenses de santé du pays mais également à plusieurs décisions prises dans la période pour adapter l'offre de soins à la survenue de l'épidémie COVID: garantie de financement à l'hôpital, prise en charge du dépistage et de la vaccination, accords du Ségur de la Santé. Selon la DREES, les comptes financiers des hôpitaux publics se sont dégradés très fortement en 2022. Après un déficit de 415 millions en 2021, le déficit des hôpitaux publics s'élève à 1,3 milliards d'euros en 2022 et entre 1,7 et 1,9 milliards d'euros en 2023. La réforme des modalités de financement devient inévitable. Sont apparues récemment des innovations comme le financement sur objectifs de santé publique, le financement à la qualité et le paiement au forfait des parcours de soins. .

Corrigendum to "Impact of territorial case management on hospital admissions for complex chronic patients in Catalonia (Spain)" [Health Policy 159 (2025) 105384]

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

2025

Health Policy 161: 105405.

https://doi.org/10.1016/j.healthpol.2025.105405

Incentivizing Hospital Quality Through Care Bundling

GRAŠIČ, K., VILLASEÑOR, A., GAUGHAN, J., *et al.*

2025

Health Economics 34(11): 2140-2160.

https://doi.org/10.1002/hec.70024

ABSTRACT Policymakers increasingly implement pay-for-performance schemes to incentivize quality of care. A key design issue when incentivizing several process measures of quality relates to whether the payment should be linked to the performance on each measure or whether the payment should be conditional on all of the process measures of quality being provided, which we refer to as "care bundling". After developing a theoretical framework of provider incentives under care bundling, we employ a difference-in-difference analysis to evaluate the Best Practice Tariff for fragility hip fracture, introduced in England in 2010, which rewards providers based on a care bundle of nine process measures that need to be jointly achieved. The design of the processes was evidence-based and the size of the bonus was significant, up to 20% of the baseline tariff. The results suggest that the policy was successful in increasing the proportion of patients for whom all of the criteria are met by 52.5 percentage points in the first 5 years after its introduction. Temporal ordering of processes might matter under care bundling, but we do not find evidence that English providers exerted less effort to meet process measures if they already failed to meet an earlier one. Overall, we find that a scheme based on care bundle, which is evidence based and uses a sizable bonus, can be effective in improving hospital performance.

Hospital Consolidation Across Geographic Markets: Insights from Market Participants on Mechanisms for Price Increases

GUDIKSEN, K. L., CABALLERO, A. E., GINSBURG, P. B., *et al.*

2025

Journal of Health Politics, Policy and Law 50(5): 681-708.

https://doi.org/10.1215/03616878-11853756

Context: Consolidation among health systems has resulted in increased prices and has caused the cost of employer-sponsored health benefits to increase much faster than inflation over the past few decades. Earlier quantitative research shows small but significant price increases resulting from transactions that expand the geographic footprint of health systems, but the mechanisms by which these cross-market acquisitions raise prices is not completely resolved. Methods: In this qualitative study, the authors interview market participants to elucidate the experience of employers, insurers, and others when negotiating with large health systems. Findings: The respondents report that employer demand for broad, stable provider networks and a lack of employer support for insurers when negotiating with large health systems undermined insurers' ability to negotiate lower prices. Additionally, the interviews identified the widespread use of restrictive contract terms by health systems and misaligned financial incentives between employers and consultants engaged to act on their behalf. Conclusions: Without government action, employers will be unable to restrain price increases that result from increasing market power of consolidated health systems. The authors identify policy levers that regulators can use to increase competition, but the oligopolistic nature of many health care markets in the United States suggest that even more significant government action may be needed.

▶ Étude des facteurs associés au lieu de décès des patients atteints de cancer et en HAD pour soins palliatifs

KHEMAR, A. D., FAUCHIER, T., CUNY, A. C., *et al.*

2025

Santé Publique vol. 37(3): 29-41.

https://doi.org/10.3917/spub.pr2.0074

Introduction : En France, alors que 80 % de la population souhaite décéder à domicile, la majorité des décès ont lieu à l'hôpital. Afin d'explorer cette discordance, nous avons étudié les facteurs influençant le lieu de fin de vie des patients atteints de cancer et admis en HAD pour soins palliatifs. Méthodes : Étude rétrospective cas-témoins à partir de la cohorte des patients pris en charge en HAD de la Fondation Œuvre de la Croix Saint-Simon durant l'année 2022. Résultats : Dans cette étude, 385 patients ont été inclus. Parmi eux, 49,9 % sont décédés à domicile et 50,1 % à l'hôpital. L'analyse multivariée a identifié deux facteurs associés à un décès à domicile : la préférence de l'aidant principal pour un décès à domicile (OR 8,53, IC95 % [4,73-15,87].

▶ Hospital Mergers and Acquisitions From 2010 to 2019: Creating a Valid Public Use Database

OH, H., MOR, V., KIM, D., *et al.*

2025

Health Services Research 60(5): e14642.

https://doi.org/10.1111/1475-6773.14642

ABSTRACT Objective To create, analyze, and distribute the Strategic Hospital Mergers & Acquisitions (M&A) Database, a detailed resource of hospital M&As from 2010 to 2019. Study Setting and Design We conducted more than 2000 Internet searches to supplement, verify, and correct M&A identifications of American Hospital Association (AHA) survey data. We assessed the accuracy of the AHA survey and performed staggered difference-in-differences analyses to estimate the impact of measurement error on treatment effects capturing shifts in our measure of hospital market power. Data Sources and Analytic Sample We analyzed 1537 M&A-related ownership changes from 2010 to 2019 from our analytic sample of 4896 unique acute care general hospitals or critical access hospitals derived from the AHA Annual Survey dataset. Principal Findings The AHA survey dataset correctly identified the M&A deal completion year for only 40.1% of M&A-related ownership changes. The improved accuracy and granular treatment indicators of our database corrected for underestimations of the impact of hospital consolidation on hospital market power, yielding an effect estimate over 200% higher than the uncorrected data. Conclusions By reducing errors in hospital M&A identification, our database can enhance the quality of studies investigating the effects of hospital consolidation on healthcare access and health outcomes.

▶ Hospital Consolidation and Quality: Opening the Behavioral Black Box

PAULY, M. V., BURNS, L. R., BENITEZ, A., *et al.*

2025

Social Science & Medicine 386: 118593.

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Compared to its impact on price and cost, much less is known about the impact of hospital consolidation on quality. This is remarkable given that prospective quality improvements are often the main benefit cited by consolidation proponents. This paper develops a two-part conceptual model that explores the circumstances and motivations under which consolidating hospitals would also decide to take actions which increase quality. It briefly reviews more than three decades of research findings that provide little evidence for claims of improved quality from consolidation. It analyzes four sets of circumstances that might predict such quality-improving actions, and finds little evidence that any of them follow mergers. The paper explores firm profit maximization as the hospital's objective but then considers an alternative model in which any financial surplus generated by consolidation is be invested in quality improvement by a utility-maximizing non-profit firm.

Hospital- And Private Equity–Affiliated Specialty Physicians Negotiate Higher Prices Than Independent Physicians

PHILIPS, A. P., RADHAKRISHNAN, N., WHALEY, C. M., *et al.*

2025

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Hospital and private equity (PE) consolidation in health care is altering the physician practice landscape, with more than three-quarters of physicians employed by these corporate entities as of 2023. We examined practice affiliation patterns for specialist physicians and those patterns' association with commercial prices for cardiology and gastroenterology services. We found that in 2023, the majority of specialists (approximately 72 percent of cardiologists and 57 percent of gastroenterologists) were employed by hospitals, whereas PE-affiliated specialists constituted a lower share and were concentrated in certain geographic regions. Hospital-affiliated specialists negotiated prices that were 16.3 percent higher for cardiology procedures and 20.7 percent higher for gastroenterology procedures compared with specialists in independent practices. PE-affiliated specialists negotiated prices that were 6.0 percent higher for cardiology and 10.0 percent higher for gastroenterology procedures. If hospital- and PE-affiliated specialists charged prices equivalent to those of independent practices, commercial health care spending would decrease by approximately $2.9 billion and $156 million, respectively. As corporate consolidation of physician practices continues to accelerate, greater antitrust enforcement and enhanced transparency in ownership structures and pricing will be essential tools for policy makers to use in containing health care costs while preserving patients' access to high-quality specialty care.

Les nouvelles approches du financement des soins hospitaliers

RUSCH, E.

2025

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Résumé Mise en place progressivement à partir de 2004, la tarification à l'activité ou T2A est devenue la principale modalité de financement des établissements de santé pour le secteur court séjour dans ses composantes médecine, chirurgie et obstétrique (MCO). De 2004 à 2024, la T2A a cependant connu de nombreuses évolutions et adaptations pour tenter de parvenir à une meilleure description clinique des patients hospitalisés, une meilleure caractérisation des types d'activités réalisées et une tarification des groupes homogènes de séjours optimale. Après deux décennies de financement par la T2A, le bilan contrasté porté sur cette modalité de financement ainsi que les difficultés rencontrées par le système de santé et notamment le secteur hospitalier ont amené les pouvoirs publics à proposer et engager une évolution des modalités de financement des établissements de santé MCO. Il s'agit d'atteindre une diversification des modalités de financement et de diminuer la part de la T2A dans le financement des hôpitaux de court séjour. Il est fait l'hypothèse que chaque modalité de financement pourra avoir un impact positif sur les organisations et les pratiques de soins en complémentarité des impacts liés aux autres modalités de financement. Les nouvelles modalités de financement introduites ou renforcées visent à accroître le niveau de qualité des prises en charge, à favoriser la continuité des soins et à mieux répondre aux besoins de santé des populations des différents territoires. Ainsi, de nouvelles modalités de financements sont déployées : financement à la qualité, dotation populationnelle, financement à l'épisode de soins ou au parcours de santé, financement d'objectifs de santé publique. La balance entre complexité des mécanismes d'implémentation et résultats attendus ainsi que l'impact de la coexistence de différentes modalités de financement seront deux enjeux riches d'enseignement. Les objectifs ambitieux poursuivis au travers de ces évolutions du financement devront faire l'objet d'une évaluation.

The Cost Effectiveness of Elective Surgical Procedures with Longer NHS Waiting Lists: A Targeted Review

TRIGG, L. A., FARMER, C., MUTHUKUMAR, M., *et al.*

2025

Applied Health Economics and Health Policy 23(5): 779-796.

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Our aim was to review the evidence for the cost effectiveness of elective surgeries with long waiting lists within the NHS in England. This is to inform understanding of national spending priorities in the context of significant demand for elective surgeries and to inform the debate on appropriate cost-effectiveness thresholds across healthcare decision making.

Are geographic variations in secondary hospital expenditure caused by supply and demand factors? Evidence from migration in England

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

2025

Soc Sci Med 383: 118439.

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Regional variations in hospital expenditure are a global concern because they may reflect unmet healthcare needs or inefficient resource use. Several recent studies have used internal migration to differentiate demand and supply causes of these regional variations. Most of these studies have focused on specific populations in competitive insurance settings and have not fully considered the timing of individual migrations. Using individual level data on 55 million patients from national Hospital Episode Statistics between 2010 and 2018, we examine geographical variations in overall hospital expenditure and in admissions (emergency and planned), outpatient visits and emergency department attendances. We estimate models similar to the need-based formula used by the English NHS to allocate resources to local commissioners, but we include individual fixed effects to capture demand factors. We find that 10-18 % of the regional variation in hospital expenditure stems from supply-side factors. This contribution is higher for ambulatory care (67.70 % for emergency department attendances and 56.89 % for specialist visits) than for hospital admissions, emergency (12.99 %) and planned (17.91 %). We also find that, after adjusting for need indicators, hospital expenditure is on average higher when individuals live in northern England and in regions with lower prices and higher than expected budget allocations. Despite this significant variation, the share attributable to supply in the English NHS is lower than other countries. Our results have implications for debates about regional variations in health care expenditure and for the importance and design of needs-based resource allocation.

First entrants in a new medical specialty: Resolving relational ambivalence during Dutch hospitalists' identity formation

VAN OFFENBEEK, M. A. G., REGTS, G. ET VOS, J. F. J.

2025

Social Science & Medicine 383: 118490.

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Our case study analyses individuals' professional identity formation and resulting identity outcomes in the first cohorts of 'Dutch hospital medicine', a specialty introduced top-down within the Netherlands in 2012 that remained controversial for a long time. First entrants in any newly introduced health occupation will have a hard time in experiencing both their professional selves and their occupation as somewhere in-between existence and non-existence. Therefore, they will need to engage in dual professional identity formation: the process by which individuals form their professional selves, parallel to, yet intertwined with, contributing to their specialty's identity development. Using 93 interviews plus supplementary sources, we zoom in on nine individual hospitalists' trajectories, complemented with 11 retrospectively validating accounts. We show how the dual nature of first entrants' professional identity formation brings along role-based tensions, evoking ambivalence in first entrants' relationships with seniors of incumbent health occupations and among themselves as peers. We find that first entrants differ in how they resolve such relational ambivalence during their professional identity formation. Three pathways emerge that result in different outcomes in terms of professional self and contribution to their specialty's development: (1) specialty-oriented incremental pioneering, (2) self-oriented adaptive role development, and (3) career-oriented struggling. We contribute, firstly, by highlighting and clarifying the relational ambivalence that dual professional identity formation in a new health occupation evokes. Secondly, as first entrants cannot be expected to form a homogeneous group, the pathways provide a model for future inquiry and inform seniors how to offer first entrants guidance.

The Significance of Definitions in Determining the Level of Community Benefits for Nonprofit Hospitals

ZARE, H. ET ANDERSON, G.

2025

The Milbank Quarterly 103(3): 809-830.

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Policy Points Nonprofit hospitals should be required to provide adequate documentation that allows the Internal Revenue Service (IRS) to evaluate whether their reported activities genuinely qualify as community benefits. To enhance the current system, rigorous data reporting requirements must be established, including mandates for hospitals to report community benefits individually on Schedule H of Form 990, clearly demonstrating how these expenditures benefit each community. The IRS, the Centers for Medicare and Medicaid Services, and public health authorities should work with hospitals to standardize definitions to improve accountability Context The American Hospital Association determined that in 2022 nonprofit hospitals spent $129 billion on community benefits. This is more than the entire budget for the US public health service. Different organizations estimate different amounts of community benefit spending depending on their definition of community benefit. Methods We used Schedule H from Internal Revenue Service (IRS) Form 990 data between 2019 and 2022 to determine the value of 17 components of community benefit and bad debt in nonprofit organizations. Using the descriptive analysis, this paper discusses the pros and cons of including certain categories of community benefit and suggests modifications to the definitions. Findings In 2022, nonprofit hospitals spent $94 billion on all 17 categories of community benefit. This expenditure included $21 billion in services that benefited the patient directly, $33 billion on services that benefited the community, and $41 billion on Medicaid shortfall. Hospitals also spent $26 billion on bad debt. Conclusions The value of community benefits varies significantly based on the definition used, even when the same data set is analyzed. Greater agreement on what community benefit means is necessary to ensure compliance with regulations regarding community benefit spending. This approach could involve coordination among the IRS, Centers for Medicare and Medicaid Services, and public health authorities to enhance accountability when working with hospital associations.

Inégalités de santé

Health Inequalities

Marginalization-related diminished returns of education level on self-rated physical and mental health among immigrants: an analysis of six high-income countries

AL-KASSAB-CÓRDOVA, A., MEZONES-HOLGUIN, E., ASSARI, S., *et al.*

2025

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ABSTRACT Objective To assess whether the association between level of education and self-rated physical and mental health is weaker for immigrants than non-immigrants, and to explore gender-based intersections. Methods We conducted a cross-sectional study using data from the Wave 1 of the Global Flourishing Study—a multi-country survey with national representativeness. Data were drawn from Australia, Germany, Spain, Sweden, the United Kingdom and the United States. Self-rated physical and mental health were measured on a 11-point scale. Level of education was categorized into four levels based on country-specific classifications. Immigrant status was defined as being born outside the country of residence. We estimated linear regression models separately for each country, including interaction terms between educational level, immigration status, and gender. Country-specific estimates were then pooled using random-effects meta-analysis. Results A total of 75,464 participants were included. Self-rated health scores increased with higher education levels, but immigrants had higher scores. However, the associations between level of education and health outcomes were significantly weaker for immigrants—they have reduced health benefits. Further, diminished health returns were more pronounced among female immigrants than their male counterparts, but these estimates had poor precision. Conclusions Due to marginalization-related diminished returns, immigrants get less health benefits from the same level of education attained than their non-immigrant counterparts. This health gap is wider among female immigrants. Structural and contextual barriers obstruct the protective effects of education among marginalized populations.

Adult Children's Education, Parental Cognitive Health, and the Role of Selection

BARR, A. B., DENNISON, C. R., LEE, K. S., *et al.*

2025

Social Science & Medicine 384: 118529.

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As the prevalence of Alzheimer's disease and related dementias (ADRD) rises in the United States, understanding social determinants of cognitive health has become increasingly important. While a robust literature highlights the downward transmission of (dis) advantage across generations, emerging research suggests that this transmission may also flow upwards from offspring to parents. Drawing on data from the National Longitudinal Study of Adolescent to Adult Health (Add Health) parent sample, we examine the association between adult children's educational attainment and parental cognitive functioning at midlife using a propensity score matching approach to account for selection on observed confounders. We find that, although offspring college attainment is associated with better parental cognitive functioning in unadjusted models, selection largely explains this relationship. Subgroup analyses, however, reveal heterogeneity in the role of selection on the confounders observed here. Among college-educated parents, children's college attainment remains significantly predictive of better cognitive outcomes even after matching on observed confounders. This is not the case for parents without a college degree. These results support a resource multiplication perspective, wherein, compared to non-college-educated parents, college-educated parents' cognitive health is more impacted by their children's socioeconomic status. Our findings add to a growing literature calling attention to selection in intergenerational processes related to cognitive health and to the importance of examining heterogeneity in intergenerational effects.

State Public Coverage of Pregnant Undocumented Immigrants and Prenatal Insurance Uptake

BELLEROSE, M., ZHENG, L., DESIR, A., *et al.*

2025

The Milbank Quarterly 103(3): 831-856.

https://doi.org/10.1111/1468-0009.70040

Policy Points Twenty-four states and the District of Columbia offer public insurance to pregnant undocumented immigrants who are income eligible for Medicaid. We found that residing in a state with public coverage of pregnant undocumented immigrants was associated with increased prenatal Medicaid coverage among immigrants and was not associated with corresponding reductions in private or other insurance coverage. Offering state public insurance to pregnant undocumented immigrants could increase immigrants' access to insurance coverage and recommended care during pregnancy. Context Health insurance coverage increases access to recommended pregnancy care, but undocumented immigrants are not eligible for pregnancy Medicaid coverage without state uptake of alternative policy options. Twenty-four states and the District of Columbia (DC) offer public insurance to undocumented immigrants who are income eligible for pregnancy Medicaid through the Children's Health Insurance Program From-Conception-to-End-of-Pregnancy option or state funds. Our objective was to examine the association between residing in a state with public insurance coverage for pregnant undocumented immigrants and prenatal insurance coverage among low-income immigrants. Methods We used 2016 to 2021 Pregnancy Risk Assessment Monitoring System responses linked to maternal nativity from birth certificate records from 19 states and DC. We compared the prevalence of any insurance, Medicaid insurance, and private or other insurance coverage of prenatal care between Medicaid income-eligible immigrants and nonimmigrants. We then estimated the association between state public coverage policy and prenatal insurance coverage among immigrants using linear regression models. Findings The study included 47,370 adults (13,271 immigrants and 34,099 nonimmigrants) who were income eligible for pregnancy Medicaid. In the ten included states with public coverage of pregnant undocumented immigrants, the proportion of immigrants with any insurance for prenatal care was 16.9 percentage points higher (95% CI, 14.9-18.9) compared with the proportion of immigrants in states without such coverage. In policy-adopting states, the proportion of immigrants with Medicaid for prenatal care was also 16.9 percentage points higher (95% CI, 14.1-19.7) compared with immigrants in nonpolicy-adopting states. We did not find differences by state coverage policy in having had private insurance coverage for prenatal care. Conclusions Providing state public insurance coverage to undocumented immigrants during pregnancy may increase overall prenatal insurance coverage by expanding access to Medicaid. We did not find evidence that extending public coverage to this population crowds out other insurance options.

▶ Is there a link between self-reported unmet needs and healthcare expenditure?

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

2025

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This study aims to investigate the factors associated with self-reported unmet healthcare needs among individuals aged 65 and older in France, as well as to determine whether healthcare expenditure and its determinants differ based on self-reported unmet needs. We use data from the 2012 Health and Welfare Survey, matched with health insurance records. Healthcare expenditure for ambulatory care-excluding inpatient care-is modeled using a regime-switching regression approach. Our findings highlight that social and behavioral disparities are the primary factors influencing self-reported unmet needs. The determinants of healthcare expenditure are generally similar, regardless of whether individuals report unmet needs, except for pre-frailty and the number of medical conditions. Surprisingly, we do not find a significant marginal effect of self-reported unmet needs on healthcare expenditure. In our view, this challenges the use of self-reported unmet needs as an indicator of access to care.

▶ Socioeconomic inequalities in developing cardiometabolic diseases and transition to depression: A trajectory analysis of large-scale population-based study

CHEN, H., WANG, X., CAO, Z., *et al.*

2025

Social Science & Medicine 384: 118542.

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Existing evidence demonstrates a high risk of developing depression in patients with cardiometabolic diseases (CMDs). However, it remains unclear whether socioeconomic inequality exacerbates the progression. We aimed to quantify the role of socioeconomic status (SES) in the progression from healthy to CMDs and their transitions to depression. A total of 376 610 participants (age 37-73 years) free from CMDs of interest, including type 2 diabetes (T2D), coronary heart disease (CHD) and stroke, from the ongoing UK Biobank study between 2006 and 2010 were included at baseline. Potential various SES groups were derived from latent class analysis using family income level, employment status and education attainment. In latent class analysis, three distinctive levels of SES (low, medium, and high) were identified. During the 15-year follow-up, we found significant associations were found between low SES and different progression stages of CMDs. In multivariate models, the hazard ratios (95% confidence intervals) for low SES vs. high SES were 1.62 (1.53-1.71), 1.23 (1.17-1.29) and 1.25 (1.13-1.38) for transitions from healthy to T2D, CHD and stroke, and 2.17 (2.03-2.30), 1.63 (1.30-2.03), 1.62 (1.30-2.03), 1.70 (1.11-2.60) for risk of transition to depression from healthy, T2D, CHD and stroke, respectively. Socioeconomic inequalities were associated with almost all transition stages from healthy to CMDs, subsequently to depression, with different magnitude of associations. These findings support the need for targeted screening programs for depression in CMD patients, and policy interventions addressing socioeconomic inequalities through improved access to healthcare, education, and economic opportunities for disadvantaged populations.

▶ Social Interventions in Times of Crisis: Community Perceptions of Integrating Social Determinants and Equity into the COVID-19 Response

CRUZ, T. M. ET WEBB, S.

2025

Social Science & Medicine 384: 118456.

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ABSTRACT In the wake of the 2020 crisis, scientific and governmental authorities sought to formally integrate social determinants and equity into the COVID-19 pandemic response. This article offers an empirical examination of COVID-19 social interventions presented as equitable with how stratified communities experienced these measures on the ground. We combine qualitative findings from a content analysis of State of California equity policies (n=12) on housing security, economic relief, and essential workforce with semi-structured interviews (n=79) conducted across three structurally unequal communities in Los Angeles and Orange County. Based on inductive analyses of our combined data sources, we find significant gaps between formal equity measures and community perceptions of social interventions. While government officials introduced novel housing and economic relief programs, both low-income and affluent communities interpreted these in reference to the pandemic as well as the pre-pandemic status quo. In South-Central LA and Santa Ana, two low-income, racialized communities disproportionately impacted by COVID-19, such measures were perceived as offering material support but were at times questioned as genuine change in policy priorities. In Huntington Beach, a major site of conservative organizing against early COVID-19 restrictions, such programs received mixed support and critique but were rarely considered in the context of addressing inequities. While social interventions may offer material support in times of crisis, our research shows how such measures also risk upholding deeper structural inequities of normal United States society.

▶ Community-based interventions to improve the health of migrant children in high-income countries: a systematic review

DI FABRIZIO, C., GONÇALVES, J. ET MARTINS, M. D. R. O.

2025

Social Science & Medicine 383: 118470.

https://doi.org/10.1016/j.socscimed.2025.118470

Background Migrant children, including those exposed to migration in utero, face structural barriers to health and social inclusion in high-income countries (HICs). Despite their heightened vulnerability, evidence on effective interventions to improve their health remains limited. Objective To synthesise experimental and quasi-experimental evidence on community-based interventions aiming to improve health outcomes for migrant children in HICs. Methods We systematically searched MEDLINE, Embase, Maternity & Infant Care Database, Global Health, and EconLit from inception to June 2025. Eligible studies evaluated interventions targeting migrant children—including those exposed during gestation—in HICs, used experimental or quasi-experimental designs, and reported any health-related outcome. Studies were excluded if they focused on narrow migrant populations (e.g. refugees), specific interventions (e.g. vaccination), institutional settings, or interventions not adapted for migrants. A narrative synthesis was conducted, supported by harvest plots to aid visualisation. Risk of bias was assessed using ROBINS-I and RoB 2 tools. The review was registered in PROSPERO (PROSPERO 2023 CRD42023468828). Results Twenty-six studies met inclusion criteria. Eight evaluated large-scale Medicaid health coverage expansions, eight assessed local school-based interventions, and ten focused on other community-based interventions—two national programmes in Sweden and Denmark, and eight local initiatives across Europe and the US. Health coverage expansions improved access to prenatal and child healthcare and, in some cases, birth outcomes. Evidence on interventions addressing behaviours, obesity, and mental health was limited or mixed, often due to small samples and short follow-up. Conclusion Coverage expansions improve migrant child health. Scalable, tailored interventions with longer follow-up are needed.

▶ Accompagnement en santé de personnes trans : freins, leviers et perspectives de professionnel·le·s recommandé·e·s par la communauté

FERRAZ, D., MABIRE, X., ROBIN-RADIER, S., *et al.*

2025

Santé Publique 37(3): 99-111.

https://doi.org/10.3917/spub.pr2.0076

Introduction : L'accès à la santé pour les personnes trans et issues de la diversité de genre est marqué par des inégalités, notamment en raison de la stigmatisation. Peu de professionnel·le·s s'impliquent dans leur accompagnement, restreignant l'accès de ces personnes au système de santé. Cet article propose une perspective originale d'analyse en explorant les expériences, les motivations et les leviers évoqués par des professionnel·le·s du champ médico-social engagé·e·s dans l'accompagnement en santé des personnes trans. Méthodes : Treize professionnel·le·s ont été intérrogé·e·s dans le cadre d'entretiens individuels puis d'un focus groupe. Une analyse thématique a révélé plusieurs leviers et freins dans leur pratique. Résultats : Les leviers comprennent un engagement à lutter contre les injustices, une relation de soin horizontale et une connaissance préalable de la communauté trans. Les principaux freins incluent le manque de formation et de recommandations officielles, la crainte de dépasser ses compétences et les contraintes d'une organisation des soins basée sur la binarité homme/femme. Les pistes d'amélioration proposées par les participant·e·s incluent la création de directives par la Haute Autorité de Santé, la production de données scientifiques robustes et l'implémentation de formations spécifiques lors de la formation initiale ou continue. Ces actions doivent être mises en place sur la base d'un travail collégial avec les personnes concernées. Enfin, les participant·e·s affirment que réduire les inégalités d'accès à la santé dépendent de l'augmentation du nombre de professionnel·le·s s'impliquant dans cet accompagnement. Discussion : Transformer le système de santé en un espace plus inclusif pour les personnes trans nécessite l'engagement des professionnel·le·s, des réformes institutionnelles et la participation active des personnes concernées, afin d'améliorer l'accès aux soins et de renforcer la qualité et l'équité en santé pour tou·te·s.

▶ Dialectical Processes of Health Framework as an Alternative to Social Determinants of Health Framework

FRIEDMAN, S. R., WALTERS, S. M., JORDAN, A. E., *et al.*

2025

American Journal of Public Health 115(11): 1868-1876.

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The social determinants of health (SDOH) framework has proven useful for research and practice in addressing the social causes of many health outcomes. However, its limitations may restrict its value as the world undergoes rapid ecological and social change. We argue that SDOH does not adequately incorporate rapidly changing or "far upstream" social processes (particularly social movements), the dialectics of social conflict and creative social innovation, or bidirectional causation. Ecosocial theory addresses some of these issues, yet dialectical frameworks offer additional insights during periods of rapid social change and disruption. The implications for research methods and practice are discussed. (Am J Public Health. Published online ahead of print September 18, 2025:e1–e9. https://doi.org/10.2105/AJPH.2025.308239)

▶ Childhood SES Gradients in Adult Functional Limitations: Does State-Level Macro-Economic Context Matter?

FULLER-ROWELL, T. E., SULTANA, S., RYFF, C. D., *et al.*

2025

Social Science & Medicine 386: 118676.

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Numerous studies document associations between childhood socioeconomic status (SES) and adult health, but less is understood about how macroeconomic context shapes these links. The current study examined whether income and income inequality measured at the state level moderated the association between parent education and functional limitations in a national sample of adults. Time-series economic data, derived from tax records (1917–2014), were merged with Midlife in the United States Study (MIDUS) data (N = 10,685; Mean age = 47.7, SD = 13.6; 51% female) by state/year to assess economic conditions during four life stages: childhood (0–15), emerging adulthood (20–25), early adulthood (ages 30–35), and midlife (ages 40–45). Results showed that higher state mean income (at all four ages of exposure) was associated with fewer adult functional limitations. Childhood income inequality (but not later periods) predicted more limitations. Childhood SES–adult health associations weakened with higher state income during childhood ($B = 0.023$, $p = .018$) and emerging adulthood ($B = 0.036$, $p = 0.026$), but not in later stages. Income inequality did not moderate SES–health links. Findings suggest that the impact of childhood SES on adult health varies by state economic context, particularly mean income, with effects dependent on exposure timing. Notably, childhood income inequality also independently predicted worse health outcomes, irrespective of state income. Future directions and policy implications are discussed.

▶ The Development of Body Mass Index from Adolescence to Adulthood: A Genotype-Family Socioeconomic Status Interaction Study

GHIRARDI, G.

2025

Social Science & Medicine 384: 118539.

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Body weight in adolescence and adulthood may result from the interplay between individuals' genetic characteristics and the social context in which they grow up, such as family socioeconomic status (SES). However, evidence on the interaction between genetic propensity for high body mass index (BMI) and family SES remains inconclusive. This study investigates whether genetic associations with BMI differ among individuals from high-SES versus low-SES families and whether these associations vary across the life course.

Using data from the National Longitudinal Study of Adolescent to Adult Health (Add Health), I assess the association between a polygenic index for BMI (BMI PGI) and BMI at four life stages: adolescence (16), early adulthood (22), adulthood (28), and later adulthood (37). Results show that the BMI PGI is more predictive of BMI among individuals from low-SES families than from high-SES families. The interaction weakens over the life course but persists among individuals with high BMI levels. These findings suggest that high-SES families may buffer genetic propensities for overweight and obesity, whereas low-SES environments may exacerbate them, increasing the risk of elevated BMI. The results underscore the importance of family socioeconomic background in shaping BMI outcomes and highlight how environmental interventions, such as promoting healthy eating and physical activity, may help reduce social inequalities in health.

Do doctors contribute to socioeconomic inequalities in health care provision? An audit experiment in Tunisia

GHOUMA, R., LAGARDE, M. ET POWELL-JACKSON, T.

2025

Journal of Health Economics 104: 103066.

https://doi.org/10.1016/j.jhealeco.2025.103066

In this paper, we explore an important but understudied driver of health inequalities: whether doctors treat patients from different socioeconomic backgrounds differently during a clinical encounter. We design an audit experiment in Tunisia, sending standardised patients with the same symptoms to 130 public and private primary care doctors for consultation. Informed by in-depth qualitative work, we vary the attitude and appearance of the patients so that they appear to be "poor" or "middle-class". We find no evidence that doctors manage patients differently, but they respond to the socioeconomic profile of patients by prescribing fewer expensive drugs and giving out more free drugs to poorer patients. We also show significant differences in communication between patients: doctors are more likely to provide more explanation to richer patients about the diagnosis, the drugs prescribed and the treatment plan. These differences are not explained by time constraints as doctors spent comparable time with both types of patients. To the extent that differences in communication with patients can lead to differences in patients' health decisions, our results suggest that doctors could contribute indirectly to health inequalities.

Gender differences in healthcare utilization across Europe: Evidence from the European Health Interview Survey

GOLINELLI, D., SANMARCHI, F., GUARDUCCI, G., *et al.*

2025

Health Policy 162: 105448.

https://doi.org/10.1016/j.healthpol.2025.105448

Background Understanding gender-based disparities in healthcare utilization is crucial for informing equitable health policy. However, cross-national evidence across multiple service domains in Europe remains limited. Objective To examine gender differences in healthcare utilization across 27 European countries and explore variability across service types. Methods We analyzed data from 257,388 adults in the third wave of the European Health Interview Survey (2019–2020). Twelve healthcare utilization indicators were evaluated, including hospital admissions, outpatient care, mental health services, and medication use. Gender disparities were estimated using regression models with inverse probability weighting based on random forest propensity scores. Results Women had significantly higher odds of using nearly all outpatient and preventive services, including general practitioners, specialists, dental care, physiotherapy, psychotherapy, and home care. They also reported higher use of both prescribed and non-prescribed medications. No significant gender differences were observed in hospitalization rates. Sensitivity analyses adjusting for health needs confirmed these findings. Considerable heterogeneity emerged across countries and service domains: Latvia, Lithuania, and Poland showed the largest disparities (e.g., ORs 1.52–1.75 for recent specialist visits), while Denmark, the Netherlands, and Ireland displayed relatively small overall gaps but large differences for specific services, such as psychotherapy and home care. Conclusions Women consistently utilize more non-acute healthcare services than men, while comparable hospitalization rates suggest differences in disease severity or care-seeking behaviors. The magnitude of these disparities varies considerably across European countries, highlighting the need for context-sensitive policies to address gender inequities in healthcare utilization.

The healthcare experiences of LGBTQ people with intellectual and developmental disabilities in the United States: A scoping review

HALLOCK, T. M., KELLY, P. J. A., CAMPAGNOLIO, A., *et al.*

2025

Social Science & Medicine 383: 118431.

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Lesbian, gay, bisexual, transgender, and queer (LGBTQ) people and people with intellectual and developmental disabilities (IDD) each face multiple systems of oppression (e.g., cissexism, ableism) that produce interpersonal, institutional, and environmental barriers to accessing healthcare services. For people with intersecting LGBTQ and IDD identities, these barriers coalesce to further restrict access to healthcare, worsening quality of health and health disparities. This scoping review explores the experiences of LGBTQ people with IDD and the barriers and facilitators they encounter when accessing care within the U.S. healthcare system. Identification of barriers and facilitators can inform multi-level intervention targets including provider knowledge, skills, and attitudes and advocacy strategies for environmental and systems-level change. A registered protocol guided the search for peer-reviewed and grey literature sources published before November 24, 2024. Sources included LGBTQ people with IDD and reported on experiences accessing and navigating healthcare services. Twenty-one articles were included in the review. The Behavioral-Ecological Framework of Healthcare Access and Navigation informed mapping of findings. Articles primarily described personal and provider factors (n = 17) that impact access to care and the healthcare environment (n = 14), while fewer described social environments (n = 7). Little attention has been paid to the built environment. Barriers included patient-provider communication challenges, difficulty finding competent providers, and the complexity of navigating healthcare systems. Facilitators included supportive social networks, affirming and accommodating providers, and healthcare policies that reduce healthcare costs and offer legal protection.

Indirect effects of immigration enforcement on health care utilization among lawfully present older Hispanics

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2025

Social Science & Medicine 384: 118540.

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ABSTRACT Immigration enforcement can indirectly affect U.S. citizens and lawfully present immigrants though “chilling effects” where immigrants avoid public resources altogether because of ambiguous immigration law, public charge rules, and through network effects. Indirect effects have been documented in take-up rates of public assistance programs, but there is a large gap in knowledge on how immigration enforcement could indirectly affect health care seeking behavior. We examined the impact of Secure Communities, an immigration enforcement program that began in 2008, on health care utilization among older lawfully present Hispanic immigrants and citizens. Using restricted geographic data from the Health and Retirement Study (HRS), we employed a staggered difference–in–differences model comparing U.S.–born Hispanic citizens and likely authorized Hispanic immigrants to a reference group of non–Hispanic, U.S.–born citizens. The main outcome was the probability of having an office visit to a health care provider. We estimate that Secure Communities led to a 16.9% decline in the probability of having a visit with a health care provider for likely authorized Hispanic immigrants relative to non-Hispanic U.S.-born respondents. These declines are not driven by health insurance coverage, and are even larger among individuals with worse health status and less education. The declines in utilization relate to chilling effects and fear of putting others at risk as the respondents in our study are not at immediate risk of deportation or other immigration consequences. As immigration enforcement increases, further efforts should be made to protect access to health care.

Communication difficulties and strategies in migrant mental healthcare: A European survey of health and social care professionals

HIEKE, G., KRYSTALLIDOU, D., TEMIZÖZ, Ö., *et al.*

2025

Health Policy 162: 105453.

https://doi.org/10.1016/j.healthpol.2025.105453

Background Globally, one billion people suffer from mental health disorders. Migrant populations face high prevalence rates of some disorders and significant barriers in accessing mental healthcare, including language-related barriers. However, knowledge about specific communication difficulties arising from language barriers and mitigation strategies is limited, as is knowledge about country-specific differences. Objective This study explores health and social care providers' (HSCPs') perceptions of mental health service accessibility for migrants, language-related communication difficulties, mitigation strategies and their perceived effectiveness, and the effectiveness of HSCP training in working with migrants. Methods We conducted a cross-sectional survey of HSCPs in nine European countries (n=629). Results HSCPs perceive mental health services as largely inaccessible for migrants facing language barriers. Cross-regional comparative analysis identified differences in the frequency of HSCPs' interactions with migrants seeking support for their mental health where language barriers are present and in how often HSCPs' reported experiencing communication difficulties when doing so. HSCPs report a lack of training in communicating with migrants across language barriers, with recent training associated with more positive perceptions of its usefulness. Communication difficulties were encountered throughout the care journey. Informal strategies, such as assistance from family and friends, and machine translation, are commonly used but seen as ineffective. Onsite professional/trained interpreters are deemed most effective, yet their availability is limited. Conclusions Findings highlight the urgent need for better communication strategies and awareness of the benefits and drawbacks of different strategies to enhance mental health service accessibility for migrants.

Relative deprivation and subsequent health, happiness, and human flourishing: A longitudinal outcome-wide analysis

KUO, C. T., HSIEH, S. H., LIAO, P. S., *et al.*

2025

Social Science & Medicine 384: 118537.

https://doi.org/10.1016/j.socscimed.2025.118537

Background Relative deprivation induced by unfavorable social comparisons due to income disparity has been linked to adverse health outcomes. However, its association with broader aspects of human flourishing has not been well established. Furthermore, most prior studies rely on cross-sectional data, limiting causal interpretation and raising concerns about reverse causality. Methods We used three waves of longitudinal panel data (2022, 2023, and 2024) from the adult population in Taiwan (N = 3413) to examine how relative deprivation, measured by the Yitzhaki Index, was associated with various subsequent health, happiness, and human flourishing outcomes. We applied an outcome-wide analytic approach, adjusting for pre-baseline covariates and exposure levels, as well as prior outcome values when available. Sensitivity analyses included the calculation of E-values and robustness checks using alternative reference group definitions. Results Relative deprivation was negatively associated with 15 out of 16 outcomes across multiple domains of human flourishing, including lower levels of general and mental health, happiness, life satisfaction, and measures related to meaning and purpose, character and virtue, social relationships, and financial stability. Among all outcomes, life satisfaction, job satisfaction, and financial-related outcomes exhibited more pronounced associations with relative deprivation. In contrast, no association was observed between relative deprivation and loneliness. E-values ranging from 1.35 to 1.74 suggested moderate robustness to unmeasured confounding. Findings were consistent across alternative definitions for constructing relative deprivation. Conclusion This study suggests that exposure to relative deprivation is a critical psychosocial stressor that compromises health and undermines multiple dimensions of well-being and human flourishing.

Associations between adverse childhood experiences and vascular indicators of atherosclerosis measured in childhood and early to mid-adulthood: A systematic review

MACRO, L. E., VON AH MORANO, A. E., HALLIGAN, S. L., *et al.*

2025

Social Science & Medicine 384: 118515.

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Objectives Adverse childhood experiences are associated with impaired vascular function and cardiovascular disease incidence and mortality, but mechanisms remain unclear. This systematic review assessed associations between adverse childhood experiences and vascular indicators of subclinical atherosclerosis, including the effects of mediating or moderating variables. Methods Searches were conducted through May 2024. Cross-sectional and longitudinal studies from childhood through adulthood, reporting cumulative measurement of ≥5 adverse childhood experiences exposures, and outcomes including ≥1 vascular indicators of subclinical atherosclerosis were included. The review was reported using Preferred Reporting Items for Systematic Review and Meta-Analyses guidelines. Results 3338 articles were identified, with 10 meeting the inclusion criteria (total participants = 4784). Five studies were longitudinal, four were cross-sectional, and one used pilot intervention baseline data. All 10 studies used retrospective adverse childhood experiences measurement. The strongest evidence was between adverse childhood experiences and arterial stiffness, with 5/8 studies showing positive associations. Positive associations between adverse childhood experiences and atherosclerotic progression (2/3 studies), and negative associations with endothelial function (2/2 studies) were identified, although quantity of evidence was small. Mediating and moderating variables were heterogeneous among studies, with only 5 measuring the effects of variables in isolation and limiting our ability to make inferences about their effects. Conclusions Findings support associations between adverse childhood experiences and subclinical atherosclerotic progression, but evidence lacks quantity and quality. Prospective evidence identifying vascular changes associated with adverse childhood experiences, including analysis of mediating and moderating variables, is required to better understand the mechanisms underpinning associated risk of cardiovascular disease.

▶ Health Hazards of Migration in People Seeking Asylum in New York City, 2023

OLIVO-FREITES, C., MIGUEZ-AROSEMENA, P., HENAO-MARTINEZ, A., *et al.*

2025

Am J Public Health 115(10): 1691-1699.

https://doi.org/10.2105/AJPH.2025.308065

Objectives. To identify hazardous migration experiences among asylum seekers and associations with psychiatric illness. Methods. We conducted a cross-sectional study of asylum seekers in a federally qualified health center in New York City from January 1 to November 30, 2023, to determine the frequency of and factors associated with hazardous migration events: physical or sexual assault, kidnapping, extortion, illnesses, and incarceration. Results. Of 530 people (median age = 28 years, 55.5% female), most were from Venezuela (38.5%), Ecuador (20.0%), and other countries in South America (27.0%). They reported physical assault (24.9%), sexual assault (1.9%), kidnapping (4.7%), extortion (48.3%), and illness (19.4%) during migration. Crossing the Darien Gap was independently associated with experiencing physical or sexual violence (as a composite outcome, adjusted odds ratio [AOR] = 2.71; 95% confidence interval [CI] = 1.47, 5.10), illness (AOR = 3.71; 95% CI = 1.70, 8.58), and extortion (AOR = 1.94; 95% CI = 1.12, 3.34). Among adults, 10.7% (95% CI = 7.7%, 14.3%) were diagnosed with psychiatric illness during their initial evaluation, and this was more common in those who were incarcerated in immigration detention centers (OR = 2.02; 95% CI = 1.13, 3.66). Conclusions. Asylum seekers journeying through the Darien Gap frequently encounter hazardous traumatic events. Detention by immigration authorities is associated with psychiatric illnesses. (Am J Public Health. 2025;115(10):1691-1699. https://doi.org/10.2105/AJPH.2025.308065).

▶ Gentrification and mental health inequities: a scoping review

PINEAULT, J., BLACHE-PICHETTE, C., LOIGNON, C., *et al.*

2025

Social Science & Medicine 384: 118547.

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Background The association between gentrification and general health has been established in the scientific literature. Less is known about the relationship between gentrification and mental health at a population level, and for specific subgroups. This scoping review aimed to document (1) the relationships between gentrification and mental health in the general population, and among specific social groups, and (2) the mechanisms which might explain why gentrification impacts the health of specific social groups more than others. Methods A framework for understanding the pathways by which neighborhood gentrification may lead to mental health inequities guided the study. We included qualitative and quantitative studies published from 2000 to 2024 in English or French. Results We identified 40 peer-reviewed studies through database searches. A mix of positive and negative effects of gentrification on mental health were found in samples of adults, while only negative effects on mental health were found for children, young adults and older adults. A mix of positive and negative effects were found in samples of residents in gentrifying neighborhoods and for residents who had lived in a gentrifying neighborhood for more than 3 years. Only better mental health outcomes were found among gentrifiers, while only worse mental health outcomes were found among long-term and displaced residents. Conclusions Findings from this scoping review can guide future research and urban planning as it documents gentrification's effects on mental health and explores why gentrification may impact the health of specific social groups more than others.

Recours à la médiation en santé chez les patients en situation de précarité : l'exemple du recours aux urgences

ROTILY, M., LAMOUROUX-DELAY, A. ET ROJAS-VERGARA, A. C.

2025

Santé Publique 37(3): 217-228.

https://doi.org/10.3917/spub.255.0217

Objectifs : Analyser la littérature sur les modalités de mise en œuvre de la médiation en santé (MS) et son efficacité sur la prise en charge des patients en situation de précarité sociale, en particulier dans les services d'accueil des urgences (SAU). Méthodes : Revue et analyse critique de la littérature sur la MS. Résultats : La littérature sur la MS reste limitée malgré une accélération des recherches publiées au cours des deux dernières années. Il existe une grande diversité dans les objectifs choisis pour utiliser la MS. Les obstacles identifiés dans la littérature sont notamment : la fragilité et la diversité des outils de MS, l'insuffisance du ciblage des bénéficiaires, les difficultés de suivi des patients, les durées d'intervention, le manque d'indicateurs d'efficacité, la variété des profils de médiateurs. Conclusions : La MS est prometteuse pour améliorer l'insertion des patients en situation de précarité dans le parcours de soins, mais son efficacité reste à prouver et ses modalités d'intervention à préciser, notamment dans le cadre des urgences afin de réduire le taux de réadmission et améliorer le parcours de soins. La formation des acteurs et la pérennisation des financements sont des actions prioritaires. Des interventions mieux définies dans leurs objectifs et leurs méthodes, une intégration complète des médiateurs en santé dans les équipes de soins, notamment des urgences, et un ciblage précis des patients pourraient accroître son impact. Des recherches approfondies sont nécessaires pour affiner les critères de sélection des patients et développer des indicateurs d'efficacité pertinents.

Evaluation of area based socioeconomic inequalities and neonatal mortality rates in France: national population based study

SARTORIUS, V., TORCHIN, H., GAULARD, L., *et al.*

2025

BMJ Medicine 4(1): e000954.

https://doi.org/10.1136/bmjmed-2024-000954

Objective To investigate the magnitude and evolution of inequalities in neonatal mortality rates by using area based socioeconomic indices in France. Design National population based study. Setting For 2015-20, data from the French National Health Data System (Système National des Données de Santé, SNDS). For 2001-08, neonatal death certificates and aggregate vital statistics data by municipality of residence. Participants Live births with a gestational age ≥22 completed weeks to a mother residing in metropolitan France, 2015-20 (4 293 403 live births and 10 869 neonatal deaths), compared with a 2001-08 study (6 202 918 live births and 14 851 neonatal deaths).Main outcome measures Differences in neonatal mortality rate (death before day 28 of life) according to the socioeconomic characteristics of the mother's municipality of residence. Comparison with data from a 2001-08 study to assess changes in socioeconomic inequalities and their contribution to the increase in neonatal mortality rate. Results The neonatal mortality rate was 2.53 per 1,000 live births in 2015-20. Five indicators, previously associated with perinatal mortality, were combined into a perinatal French deprivation index (P-FDep) for the main analysis. P-FDep was categorised into five equal groups (deprivation groups 1-5) for comparison with other research and into 10 equal groups (deprivation groups 1-10) for more granular analyses, with group 1 being the least and group 5 (or group 10) the most deprived group. The rate in the most deprived compared with the least deprived group for P-FDep was 1.71 (95% confidence interval 1.60 to 1.83) times higher, based on the analysis of deprivation groups 1-5. A mortality gradient existed across the groups, translating into 2496 excess deaths (23.3%) when the rate in the least deprived group was applied to all areas. The gradient was more marked when deprivation groups 1-10 were used (relative risk 1.88, 95% CI 1.71 to 2.07 for the highest to the lowest deprived group). Compared with 2001-08 (neonatal mortality rate 2.39 per 1000), the rate remained constant in the least deprived areas, but worsened in the most deprived areas (+10.1% and +11.7% for groups 4 and 5, respectively), increasing the relative risks between the highest and lowest groups, which were 1.54 (95% CI 1.46 to 1.62) for deprivation groups 1-5 and 1.67 (1.55 to 1.79) for deprivation groups 1-10, in 2001-08.Conclusions In this study, the socioeconomic level of the mother's place of residence was strongly associated with the neonatal mortality rate. The data showed that inequalities have widened, contributing to the increase in the neonatal mortality rate.

▶ Better health, but growing social and health inequalities among young adults in Germany due to educational expansion? - A counterfactual mediation analysis

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2025

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Purpose Based on theoretical and empirical work on the significance of school education for health, this study examines the influence of educational expansion on self-rated health and the development of social and health inequalities between educational groups among young adults in Germany. Methods We used data from the German Socio-Economic Panel study from 1995 to 2020, focusing on individuals aged 25 to 39 years. Health was measured using the single item 'self-rated health'. Social inequalities between educational groups were examined in terms of professional position, unemployment rates and household income. Logistic regression analyses were applied to examine health trends. The Relative and Slope Index of Inequality (RII /SII) were calculated to examine the development of social and health inequalities. The influence of school education, professional position, unemployment rates and income on the health trends was analyzed using causal mediation analysis. Results We found a beneficial effect of educational expansion on SRH of young adults. At the same time, social and health inequalities have increased between educational groups in terms of relative and absolute measures of inequalities. The deterioration in health of young adults with low education could be partly explained by the increase in low-skilled jobs and low incomes. Conclusions Our findings suggest that a high educational attainment is becoming increasingly important for success in the labor market and good SRH. Young adults with a low level of education are becoming a smaller but increasingly vulnerable group, which poses challenges for future prevention.

▶ The socioeconomic trajectories followed during early adulthood contribute to inequalities in cardiometabolic health by age 24 years

WINPENNY, E. M., STOCHL, J., HUGHES, A., *et al.*

2025

Social Science & Medicine 385: 118634.

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Introduction Socioeconomic position is strongly associated with cardiovascular health. However, little is known about the short-term health impacts of socioeconomic exposures during early adulthood. In this study we describe socioeconomic trajectories of early adulthood (age 16-24y), and assess associations of these trajectories with cardiometabolic health at age 24y. Methods Participants of the Avon Longitudinal Study of Parents and Children (ALSPAC), with data across age 16y to 24y (2007–2017) were included (n = 7568). Longitudinal latent class analysis identified socioeconomic trajectories, based on education and employment data across ages 16–24y. Cardiometabolic outcomes at age 24y comprised anthropometric, vascular, metabolic and cardiovascular structure and function measures. We modelled differences in cardiometabolic outcomes at age 24y across the socioeconomic trajectory classes, adjusting for childhood socioeconomic position, adolescent health behaviours and adolescent health. Results Four early adulthood socioeconomic trajectories were identified: (1) Higher Education (41% of the population), (2) Extended Education (9%), (3) Part-Time Employment (21%), and (4) Early Employment (29%). Associations between socioeconomic trajectories and cardiometabolic outcomes differed by sex. Among males, the Higher Education and Extended Education trajectories showed a healthier profile across cardiometabolic risk factors at age 24y, and the Part-time Employment trajectory the least healthy profile. Among females there was less clear distinction between the trajectories, and the pattern across different outcomes was not consistent. Conclusion The newly identified 'Part-time Employment' trajectory showed the least healthy cardiometabolic profile. Further research should focus on this group to understand the exposures contributing to poor cardiometabolic health in this sector of the population.

The Plight of Marginalized Populations in 2025: The Assault on Health Equity Through a Systems Lens

WOOLF, S. H., CHIN, M. H., *et al.*

2025

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Méthodologie – Statistique

Methodology – Statistics

The Impact of Incentives on Valuing Health Risks

GIL-MOLTO, M. J., HOLE, A. R., ANDERSSON, H., *et al.*

2025

Health Economics 34(10): 1907-1920.

https://doi.org/10.1002/hec.70011

ABSTRACT Recent research has found that health risk values elicited using Discrete Choice Experiments (DCEs) may be inadequately sensitive to the magnitude of the risk reduction, a phenomenon referred to as insensitivity to scope. This paper investigates the use of DCEs to estimate the value of a statistical life (VSL) under different experimental conditions. In particular, we use an experimental design where in one experimental arm we carry out a standard unincentivised DCE as in the existing literature, while in the other experimental arm we carry out an incentivized version of the DCE with real payments. Our findings suggest that the incentive has an impact on the results, in the sense that the VSL estimates are higher in the unincentivised arm of the experiment. However, we find evidence of external insensitivity to scope in both experimental arms and only weak evidence of stronger internal sensitivity to scope in the incentivized arm. Hence, our results suggest that a lack of scope sensitivity is unrelated to the hypothetical nature of the payments in stated-preference valuations of health risks.

Design and application of a survey for measuring multidimensional access to health services

GONZÁLEZ, G. P., GERI, M., MORENO, M. S., *et al.*

2025

Journal of Healthcare Quality Research 40(5): 101154.

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Objectives Access to health services is a critical factor in ensuring equitable healthcare delivery. Understanding patient perspectives on barriers and obstacles to healthcare access is essential for improving health outcomes. This study aims to design and test an instrument to assess self-perceived access to health services across different levels of care, encompassing all process dimensions. Methods The survey, constructed with an interdisciplinary approach, is administered at the household level. It was validated by experts and approved by a Bioethics Committee. This survey was conducted in a medium-sized city in Argentina. Results The validated instrument provides a comprehensive tool to investigate, from the patient's perspective and preferences, the barriers that prevent a health need from becoming a demand and the obstacles to effectively using the needed healthcare service. The implementation of the survey revealed significant insights into these issues. Conclusions Our instrument offers valuable insights into the patient-perceived barriers to healthcare access. It is a robust tool for identifying the obstacles that impede the utilization of health goods and services in the different levels of care, thereby improving healthcare delivery systems.

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

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

2025

Social Science & Medicine 383: 118352.

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

Time on Your Side: Aggregating Data in Difference-In-Differences Studies

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2025

Health Serv Res 60(5): e14636.

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OBJECTIVE: To compare the performance of difference-in-differences estimators fit to data aggregated to different time scales. STUDY SETTING AND DESIGN: In simulations, we generated monthly observations for 50-100 units over 6 years from both a parametric model and a resampling simulation. The simulation scenarios varied panel balance, treatment timing, and true treatment effects. Our target parameters were static and dynamic average effects of treatment on the treated (ATT) estimated via linear regression (for common timing scenarios) and Callaway and Sant'Anna (2021) estimators (for staggered timing scenarios). We compared estimates from monthly, quarterly, and yearly data using bias, standard error, root mean squared error (RMSE), power, and Type I error. We also conducted a case study to illustrate the real-world impacts of these decisions. DATA SOURCES AND ANALYTIC SAMPLE: We used data from a study of police retraining for the resampling simulations and case study. These data included counts of use-of-force incidents and dates of training enrollment for 8614 officers each month from 2011 to 2016. PRINCIPAL FINDINGS: Results from the simulation varied across performance metrics, estimation methods, target estimands, and data structures. In general, the choice of time aggregation was more consequential when estimating dynamic (versus static) treatment effects, in unbalanced (versus balanced) panel data, and in the resampling simulations (where data had less autocorrelation). Although time aggregation mattered little in many scenarios, coarser aggregation was preferable in resampling simulations of staggered timing scenarios. The re-analysis of police training data was sensitive to time aggregation. CONCLUSIONS: In many scenarios, time aggregation has little impact on difference-in-differences estimators. However, when estimating dynamic effects, especially in staggered timing settings and unbalanced data, we found a tradeoff between precision and power, with finer aggregations being more powerful but less precise. In addition, estimators that use a single reference time point are more sensitive to noise in data measured at finer time scales.

Preference Inversion in Discrete Choice Experiments: A Novel Test of the Emoji Scale

THAI, T., ENGEL, L., RIDE, J., *et al.*

2025

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Preference inversion - where preference estimates do not align with the hierarchical order of attribute levels(1)- remains a concern in health valuation studies. To address this, we developed a novel visual aid, the emoji scale, comprising five Apple Unicode emoji characters to represent five levels of a health-related quality-of-life measure. Using a case study of the Recovering Quality of Life – Utility index instrument, we explored whether the emoji scale could reduce preference inversion and improve respondent experience in discrete choice experiments (DCEs). We conducted a between-respondent comparison involving 2,024 Australian adults, randomly allocated to one of four arms:(1) standard text-only choice tasks, (2) emoji & text (combined), (3) emoji-only (no text), and (4) text with purple colour-coding. We estimated value sets derived from each format and assessed differences in perceived task difficulty, engagement, and preference inversion using t-tests and model comparisons. Results showed that utility decrements from the emoji & text were closely aligned with those from the standard text-only format. Importantly, the emoji & text reduced preference inversion and was associated with lower reported task difficulty and higher engagement compared to other formats. These findings suggest that pairing emojis with text may enhance respondent understanding and data quality in health valuation tasks, without compromising the validity of the resulting value sets. While further work is necessary to fully understand the legitimacy of the emoji scale as an effective visual aid for conveying attribute level ordering, the emoji & text format offers a promising approach to improving DCEs.

▶ Social vulnerability indices for proactively identifying at-risk individuals in healthcare: a systematic review

VALENTIN, G., PEDERSEN, P., MARIBO, T., *et al.*

2025

European Journal of Public Health 35(5): 844-854.

https://doi.org 10.1093/eurpub/ckaf067

Social vulnerability indices (SVIs) have the potential to guide risk stratification and support socially differentiated interventions to improve healthcare equity. However, their applicability in clinical settings remains uncertain. This systematic review synthesizes evidence from individual-level SVIs, focusing on (1) how social vulnerability is defined, (2) the domains and items covered, and (3) their ability to predict poor health outcomes. We searched the Medline, PsycInfo, Embase, and Web of Science databases from inception to 31 January 2024 for studies linking individual-based SVIs with poor health outcomes in adult populations in Europe, North America, and Australasia. Data were extracted independently by two authors, and the certainty of evidence was assessed using the GRADE approach. A narrative synthesis addressed the review's aims, with thematic synthesis for the first two and a vote-counting approach for the third. Most SVIs included domains like income, social support, living situation, and educational attainment, with over 50% covering these factors. A consistent association was found between higher social vulnerability and poorer health outcomes. However, none of the identified SVIs were prospectively tested in clinical settings. The overall certainty of evidence was assessed as low due to retrospective study designs and significant heterogeneity. This review highlights the potential of SVIs to predict poor health outcomes, though their lack of prospective validation limits current use. Future research should focus on adapting and testing SVIs that prioritize key socioeconomic and social support domains while adopting a simple and pragmatic approach.

Politique de santé

Health Policy

▶ Frameworks, theories and models used in the development of health policies: A systematic review of systematic reviews

DIAMANDIS, S., THORNLEY, T., BENRIMOJ, S. C., *et al.*

2025

Health Policy 162: 105451.

https://doi.org/10.1016/j.healthpol.2025.105451

Health policies are established to address a specific health need, however, are not always the result of a rational process of evaluation or developed using established policy frameworks, theories or models (FTMs). Greater utilisation of FTMs in health policy making may provide further insight into policy development and overcome barriers to policy inaction. The present review aimed to analyse the FTMs and their components underpinning health policy development, and health settings to which they are applied.

Prévention

Prevention

New government, old habits? The opportunity for a turning point in prevention health policies in Germany is now!

ANDREAS, M., KELLERMANN, L., LEWERICH, L., *et al.*

2025

Health Policy 161: 105409.

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Germany has long lagged behind other high-income countries in terms of implementing evidence-based prevention policies. This is reflected by the relatively low life expectancy of the population, high numbers of non-communicable diseases and health inequality in the country. Against this backdrop, we discuss the initial plans of the new German government for prevention, and suggest a way forward. By shifting from a focus on curative measures to evidence-based, population-level interventions, Germany can improve health outcomes, reduce inequalities, and save costs. Strategic leadership and a coherent national prevention strategy are essential to achieve this transformation.

New political science analysis of the renewed push for preventive health: 'Can it be any different this time around?'.

CAIRNEY, P., BOSWELL, J., MAHMOOD, H., *et al.*

2025

Social Science & Medicine 384: 118568.

https://doi.org/10.1016/j.socscimed.2025.118568

The idea that 'prevention is better than cure' is often treated as self-evident in health policymaking: who would not want to shift resources from mitigating acute problems to their prevention? However, there is always a gap between rhetorical commitments and practice, producing cycles of enthusiasm then limited progress. If prevention returns to the top of the agenda, how can this time be different? To answer that question, we applied new political science analysis to recent efforts to promote prevention via Integrated Care Systems (ICSs) in England. We theorise persistent barriers to prevention caused by limited: clarity regarding its meaning in practice, congruity with routine policy delivery, and capacity to sustain major changes. We engaged with local and national health and care policy practitioners to explore how these barriers have manifested in practice. We convened seven focus groups (2024) containing sixty participants, then used qualitative thematic analysis to categorise challenges and responses. This approach helped to identify barriers including: short-termism; financial and operational pressures; routine limits to cooperation; untapped community assets; and limited opportunities for peer learning. It also sparked discussion on feasible enablers, including: systems leadership; collaboration to make the wider determinants of health 'everyone's business'; techniques to frame preventive projects as deliverable and evidence-backed; 'institutionalising' prevention; and the better use of data. Paradigm shift towards prevention requires long-term repeated efforts to bolster political support for change and support local collaboration to build and maintain systemic capacity. Political science-driven analysis helps to frame and support this process.

Examining the continuity of modifiable cancer-risk behaviors from youth into adulthood through prospective longitudinal studies: A scoping review

PARADA, M. L., HORN, J. ET CAMBRON, C.

2025

Social Science & Medicine 384: 118534.

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Objective Modifiable health behaviors including tobacco and alcohol use, poor diet, and low physical activity increase risk for developing multiple cancers. Longitudinal research suggests that risky behaviors initiated in youth may persist into adulthood. This scoping review maps prospective longitudinal studies examining the continuity of these behaviors from youth into adulthood. Methods Four electronic databases were searched for prospective longitudinal studies on the continuity of tobacco use, alcohol consumption, poor diet, and low physical activity from youth (< 18) into adulthood (≥ 18). The scoping review was guided by the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) and methodology outlined by the Joanna Briggs Institute. Three independent reviewers used Covidence review management software for screening and data extraction. Results Seventy-one studies met inclusion criteria. The majority of studies examined alcohol use (58%) and tobacco use (24%), with fewer studies addressing low physical activity (6%) or poor diet (4%). Over 90% of studies reported continuity of behaviors from youth into adulthood. Persistence was most consistently observed for alcohol and tobacco use, with limited evidence supporting continuity of poor diet and low physical activity. Conclusions This review summarized available prospective longitudinal research on the continuity of health risk behaviors from youth into adulthood. While there is evidence for the continuity of youth alcohol and tobacco use into adulthood, notable research gaps exist for poor diet and physical activity, limiting our understanding of how these behaviors track across development. Implications for future cancer research are discussed.

A national multisectoral commission: Contours and Contributions to the Population Health Development

PAUL, P.

2025

Health Policy OPEN 9: 100144.

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BACKGROUND: The World Health Organization (WHO) Global Action Plan for the Prevention and Control of Non-communicable diseases (NCDs) 2013-2030 emphasises that effective NCD prevention and control requires leadership, coordinated multisectoral and multistakeholder engagement across a broad range of sectors, and partnerships with relevant civil-society organisations and private-sector entities. This study identifies country specific policy instruments and levers, and thus, unfolds the context specific contributions of a national multisectoral commission to tackle the problems of NCDs. METHODS: The data from twenty-six countries (low-income countries: 2, lower-middle-income countries: 9, upper-middle-income countries: 11 and high-income countries: 4) spread over all six WHO regions are analysed at two levels - the first level of analysis examines the correlation between having a national multisectoral commission and the select risk factors for NCDs. In the second level of analysis, a series of regression-based models is applied for understanding the effect of having a national multisectoral commission on the probability of dying from any of four NCDs (cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases), and also on the health adjusted life expectancy (HALE) at birth and at age 60 years. RESULTS: Our results comprehend that (a) a national multisectoral commission is acting through a varied combinations of different instruments and levers, and such combinations do not follow any definite pattern, and (b) a consistent improvement of HALE is better sustained with having a national multisectoral commission for NCDs. CONCLUSION: To conclude, this study establishes the need for further research on the performance of a national multisectoral commission, agency or mechanism for NCDs with a three-dimensional approach that is with an approach that includes (1) the national multisectoral commission, agency or mechanism for NCDs with its attributes, (2) the distribution of risk factors across different population groups, and (3) the demography and its determinants of health for the population.

Comparing COVID-19 Acute And Postacute Medical Spending By Vaccination Status For Child And Adult Medicaid Enrollees

PIKE, J., KOMPANIYETS, L., HURLEY, L. P., *et al.*

2025

Health Affairs 44(10): 1218-1225.

https://doi.org/10.1377/hlthaff.2025.00050

Although COVID-19 vaccines have been shown to be highly effective in preventing severe illness, hospitalization, and death, information on the economic benefits of COVID-19 vaccination is lacking. Using data from a comprehensive, integrated health system, we linked health plan data and electronic health records to vaccination data to compare the average medical expenditures of vaccinated versus unvaccinated patients diagnosed with COVID-19. We examined expenditures during acute (within thirty days after diagnosis) and postacute (at least thirty days after diagnosis) periods from April 2021 through July 2022. Among children, average acute medical expenditures were $194 less for vaccinated than unvaccinated cases and among adults, $1,743 less for vaccinated than unvaccinated cases. Medical expenditures in the postacute period were not statistically different by vaccination status. The findings suggest that COVID-19 vaccination is associated with lower medical expenditures in the acute period. Vaccination continues to be important for reducing the economic impact of COVID-19.

Which women go for screening?

SEVILLA-DEDIEU, C., LE GUERN, M., COQUOZ, C., *et al.*

2025

European Journal of Public Health 35(5): 992-998.

https://doi.org/10.1093/eurpub/ckaf128

Cancer accounts for approximately one-third of deaths in developed countries. Preventing cancer, notably by detecting new cases early, is thus crucial. In the European Union (EU), screening rates have been recommended for several types of cancer; however, most EU countries are still not meeting them. Determining how we can improve people's adherence to screening is necessary. This study aimed to explore the characteristics of women associated with being up-to-date on mammograms or Pap smears; notably, we wanted to determine the extent to which women's attitudes towards risk play a role in their adherence to screening. The sample comprised 1411 women who responded to a telephone survey. The survey data, including sociodemographic characteristics, health information, attitudes towards the future, and attitudes towards risk, collected via the Domain-Specific Risk-Taking (DOSPERT) scale, were supplemented by medico-administrative data. The factors associated with undergoing either a mammogram or a Pap smear in a timely manner were similar. Two favourable factors were found: the number of children and a high level of education. In contrast, being older or having a higher DOSPERT score for risk-taking appeared to be negatively associated with timely screening. The fact that women's attitudes towards risk seem to have a strong impact on their adherence to medical recommendations is a finding that should be considered (e.g. by health professionals or in prevention campaigns) regarding increasing women's awareness of the importance of regular cancer screening.

Prediabetes in practice: Examining the stratified medicalization of diabetes prevention

VASQUEZ, E.

2025

Soc Sci Med 384: 118513.

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Drawing on multi-sited ethnographic data examining the diagnosis and treatment of prediabetes in three socioeconomically distinct clinics, this paper illuminates how this medicalized approach to diabetes prevention amplifies inequities in care across lines of class-based and racialized difference. While all three clinics adhere to a standard definition of the predisease, prediabetes is performed in markedly different ways across these clinics, patterned by their diverse institutional structures and assumptions about their patient populations. This has unequal consequences for patients' understandings of their bodies and their health futures, and patients diagnosed with prediabetes are subject to distinct forms of discipline, empowerment, and even abandonment.

Psychiatrie

Psychiatry

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

BARBALAT, G., DE ROZARIO, R. ET FRANCK, N.

2025

Health Policy 161: 105419.

https://doi.org/10.1016/j.healthpol.2025.105419

ABSTRACT Background The mental health burden on Emergency Departments (EDs) is significant. Community-based mental health services are key to lowering ED visits by addressing mental health needs proactively. Objective To examine the impact of CAdEO, a community-based patient assessment and triage service launched in 2020 in Lyon, France, on psychiatric ED visits among new patients at a local psychiatric hospital. Methods We first used a quasi-experimental interrupted time series design to compare populations exposed (new patients) vs. non-exposed (patients currently under care) to CAdEO from 2015 to

2023. Second, we investigated how the quality of service functioning, measured by delays between referrals and consultations, affected ED visits. Results Exposure to the CadEO service was associated with a 0.5% daily decrease in mental health-related ED visits (Risk ratio (RR): 0.995; 95% Confidence Interval (CI): 0.991, 0.999). Reducing the waiting times for triage from 12 days to 4.7 days over a six-week period was associated with a 26.5% decrease in ED presentations (RR: 0.735; 95% CI=0.548, 0.986). Additionally, males demonstrated a significant response to the ongoing influence of the service over time, while females were more responsive to cumulative changes in waiting times. Shorter CAdEO waits were linked to lower ED visits for mood and personality disorder patients. Conclusions This study suggests that a community-based patient assessment and triage service may help reduce the overall demand for mental health care in ED. Our findings also highlight the necessity for tailored approaches that consider gender and specific mental health conditions.

The problem with rights in mental health: how law and rights undermine efforts to end coercion in psychiatry

BARBALAT, G., DE ROZARIO, R. ET FRANCK, N.

2025

Social Science & Medicine 384: 118509.

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This paper proposes a critical analysis of the role of law and rights in the use of coercive practices in psychiatry, which are increasing in Global North countries. The first part focuses on rights as a framework for coercion. The development of mental health legislation has not altered the historical criteria for coercive psychiatric practices but has formalized the link between mental health and risk or incapacity, with rights providing the framework for coercion and maintaining the status quo. The second part examines rights as a reason for coercion. Following the recognition of rights in mental health, the right to treatment has taken precedence over the right to consent and refuse care, and over procedural rights. Legislative and judicial initiatives have multiplied in recent years in the name of rights and through a compassionate approach, facilitating increasingly implicit, negotiated, and "consented to" psychiatric coercion practices. The third part analyzes rights as an obstacle to individual, collective, and political mobilization. It examines the barriers individuals face in claiming their rights in court, the impossibility of asserting structural rights violations within the justice system, and the inability to collectivize rights claims, highlighting how implementing marginalized groups' rights contradicts the legal system's foundations. Finally, by monopolizing and directing the struggle concerning psychiatric coercion, rights prevent the denunciation of the structural issues at its core.

Veteran Mental Health Emergency Care Utilization Following SARS-CoV-2 Infection

CHEN, J. I., NIEDERHAUSEN, M., BUI, D. P., *et al.*

2025

Health Serv Res 60(5): e14622.

https://doi.org/10.1111/1475-6773.14622

OBJECTIVE: To evaluate whether Veterans infected with SARS-CoV-2 have an elevated risk for needing mental health emergency care (MHEC) relative to uninfected comparators, as measured by emergency department or urgent care clinic utilization for a mental health diagnosis. DATA SOURCES/EXTRACTION: Data from Veterans Health Administration (VHA), VHA-paid, and Centers for Medicare & Medicaid-paid services were used to identify incident MHEC use within 1 year of infection for Veterans with a SARS-CoV-2 infection and matched comparators. STUDY DESIGN: This was a national, retrospective cohort study that leveraged a target trial emulation framework to examine long-term outcomes of SARS-CoV-2 infection among Veterans enrolled in VHA care. Uninfected comparators were matched based on month of infection, demographic, clinical, and health care utilization characteristics. We calculated cumulative incidence rates per 10,000 persons and utilized Cox regression models to estimate hazard ratios (HR) for MHEC up to one year post-infection. PRINCIPAL FINDINGS: The cohort included 207,968 Veterans with SARS-CoV-2 and 1,036,944 comparators. The 365-day incidence of MHEC use was greater among SARS-CoV-2 patients than comparators (HR = 1.48; 95% CI: [1.44, 1.52]). Patients with SARS-CoV-2 had a higher hazard for MHEC use than comparators in all timeframes analyzed. CONCLUSIONS: SARS-CoV-2 infection was associated with increased MHEC use. Active care coordination with existing mental health treatment providers may help mitigate post-infection mental health distress. Future research should explore specific contextual factors contributing to MHEC, such as gaps in continuity of care.

Vers une psychiatrie sans soin ? Extrapolations critiques à partir du paradigme du non-soin américain

DELAPORTE, J. F.

2025

L'information psychiatrique 101(7): 523-527.

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À partir de l'analyse du philosophe Alexandre Monnin sur le « non-soin » en médecine aux États-Unis, cet article propose une lecture critique des évolutions ces vingt dernières années de la psychiatrie publique française. Il met en évidence une transformation insidieuse du soin : désinvestissement des institutions, tri implicite des patients, injonction à l'autonomie, montée des plateformes expertes et pilotage algorithmique. Ces dynamiques tendent à redéfinir le soin comme un processus conditionnel, fragmenté, centré sur l'évaluation et la conformité à des normes prédictives, plutôt que sur une relation clinique durable. Sans qu'il soit possible de parler d'un basculement explicite vers le non-soin, l'enchevêtrement progressif de ces logiques soulève des interrogations sérieuses quant à l'avenir des principes éthiques, cliniques et institutionnels qui ont modelé la psychiatrie publique française depuis la deuxième moitié du vingtième siècle.

The Role of Norms and Acculturation in Migrants' Willingness to Seek Mental Health Care: Results from a Large Preregistered Study

HARRIS, S. M., BYE, H. H. ET KUNST, J. R.

2025

Social Science & Medicine 384: 118598.

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Aims This study investigated the role of perceived social norms and acculturation orientations in shaping migrants' willingness to seek mental health care. Specifically, we examined perceptions of help-seeking norms, presumed approval by family and friends, and the moderating role of migrants' acculturation orientations. Methods The study used a preregistered design with a sample of 2,768 people with a migrant background from six countries (Afghanistan, Eritrea, Lithuania, Poland, Syria, and Ukraine). Participants completed a web-based survey assessing their willingness to seek help, perceived approval by family and friends, perceived help-seeking norms among people from their own group (same country of origin and gender) and among Norwegian majority members, and acculturation orientations. We used multilevel regression models to test our predictions. Results Participants perceived their own group as less willing to seek help than themselves; in the Ukrainian sample, this tendency was attenuated among women. All perceived norms had a significant and positive association with own willingness to seek help, but family and friends' approval had the strongest association. Exploratory analyses showed that participants rated the majority group as more willing to seek help than both participants themselves and members of their own group. Critically, acculturation orientations moderated the associations. Conclusions Our results suggest that participants may show more willingness to seek help than they believe others in their own group do. This misperception of norms may contribute to hindering help-seeking. While all group norms played a role in own willingness to seek help, presumed approval from family and friends may play a more pivotal role. The role of own group and majority group norms depends on individuals' acculturation orientations. Tailored interventions should consider these factors when aiming to facilitate access to mental health services among diverse migrant populations.

Disparities in Access to Serious Mental Illness Care Following the Implementation of Value-Based Payment Reform in the Oregon Medicaid Program

LE COOK, B., MCCONNELL, K. J., PARRY, G., *et al.*

2025

Med Care Res Rev 82(5): 376-386.

https://doi.org/10.1177/10775587251339969

Racial and ethnic disparities in mental health care access are especially consequential for the health outcomes of Medicaid beneficiaries living with serious mental illness (SMI). This descriptive study of Oregon Medicaid claims data assessed for disparities in access to SMI care for Oregon's adult Medicaid beneficiaries from 2010 to 2019, examining changes following the implementation of value-based payment (VBP) in 2012. Multivariable regression analyses compared changes in access to SMI care, pre- and post-VBP implementation, by race and ethnicity. Relative to White beneficiaries, VBP implementation was associated with net increases of 0.28% (95% confidence interval [CI]: [0.01%, 0.55%]) in the rate of access among Black beneficiaries (a complete reduction of the pre-VBP disparity) and 0.34% (95% CI: [0.17%, 0.51%]) among Latinx beneficiaries (narrowing but not closing the pre-VBP disparity). The Oregon policy's focus on access, equity, and beneficiaries with mental illness might have contributed to the observed reductions in disparities.

▶ Projets territoriaux de Santé mentale. Où en est-on ?

LEGUAY, D.

2025

Pratiques en santé mentale (3): 62.

https://shs.cairn.info/revue-pratiques-en-sante-mentale-2025-3

Une politique de santé mentale globale, à la fois transversale, décloisonnée et participative. Ce numéro de notre revue Pratiques en santé mentale est cette fois consacré à un dispositif particulièrement novateur institué par la « loi de modernisation de notre système de santé » de janvier 2016 : il s'agit des projets territoriaux de santé mentale, désormais appelés par tous PTSM, Projets Territoriaux de Santé Mentale, (tant il est vrai qu'il existe une profusion de sigles dans le champ du sanitaire et des affaires sociales). Le PTSM, dixit le législateur, vise à « l'amélioration continue de l'accès des personnes concernées à des parcours de santé et de vie de qualité, sécurisés et sans rupture ». La notion de parcours de santé et de vie est autrement plus large que le parcours de soins. Cela traduit clairement que si les soins psychiatriques font partie intégrante des parcours, ils sont à l'évidence incontournables, ces soins s'intègrent dans un ensemble diversifié d'étayages : prévention, diagnostics précoces, accompagnements sociaux et médicosociaux, favorisant une vie optimale pour « les patients » devenus « usagers voyageurs » sur des itinéraires décloisonnés orientés rétablissement. A l'heure de la reconnaissance de la santé mentale comme grande cause nationale ces projets territoriaux sont incontournables pour conforter une politique de santé mentale globale, à la fois transversale, décloisonnée et participative.

▶ Parenthood and mental health: Findings from an English longitudinal cohort aged 32

MANSFIELD, R. ET HENDERSON, M.

2025

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Studying the mental health effects of parenthood is challenging due to unequal selection into parenthood. This study used data from the English longitudinal cohort Next Steps (N = 7095) to examine the association between parenthood, psychological distress and life satisfaction at age 32, accounting for observable selection effects. A lifecourse perspective offered insights into early life inequalities that influence fertility decisions and parent's life stage, which, in turn, may shape the extent to which parenthood is a determinant of mental health. Results indicate a small positive effect of parenthood on mental health, with males reporting better outcomes than females. Parenthood had a greater impact on improving life satisfaction than reducing psychological distress. In the female sample, ethnic minority parents reported lower psychological distress than White parents, while ethnic differences in mental health were more pronounced among males without children. Sexual minorities reported higher psychological distress, particularly LGBQ female parents. Having a cohabiting partner and dual earnings protected mental health, especially for parents. Older age at first child was also associated with better mental health while a greater number of children was linked to worse mental health for females but not males. Among people without children, fertility intentions influenced mental health—males who did not want children reported the lowest life satisfaction, whereas for females, it was those uncertain about their fertility intentions. This study highlights modest mental health benefits of parenthood while emphasising social inequalities. Future research should explore long-term mental health trajectories and policies that mitigate mental health burdens associated with different fertility choices.

▶ Continuité des soins : rêve ou cauchemar ?

MARSILI, M.

2025

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La continuité des soins en psychiatrie demeure aujourd'hui un enjeu majeur et une source de questionnements. Cet article met en lumière les divergences persistantes entre les politiques de santé mentale et les pratiques cliniques. Trop souvent, ces dernières semblent privilégier la sécurisation des lieux d'hospitalisation au détriment du renforcement de l'alliance thérapeutique, particulièrement cruciale pour la prise en charge des patients complexes. Pourtant, les connaissances actuelles en pharmacologie, en psychothérapie et dans le domaine psychosocial offrent des pistes de travail concrètes pour surmonter les obstacles qui entravent une réelle continuité des soins en psychiatrie.

Time, diagnosis, and medication: The institutional circuit of billing in community mental health care

MELINO, K., OLSON, J., SPIERS, J., *et al.*

2025

Social Science & Medicine 383: 118455.

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This study explored the social organization of Psychiatric Mental Health Nurse Practitioners' (PMHNPs') practice in community mental health care settings. Using institutional ethnography (IE), we examined the everyday work practices of PMHNPs to uncover the ruling relations that govern their work with patients with serious mental illness who live within conditions of poverty, violence, houselessness, and discrimination. Nine PMHNPs from outpatient community mental health clinics in a large California city participated in the study. Data collection included in-depth interviews, clinic observations, and analysis of relevant clinical and organizational texts. The analysis revealed how the mental health system's electronic health record (EHR) organizes PMHNPs' work by time, diagnosis, and medication to align their patient care with billing requirements. The Specialty Mental Health Services Medi-Cal Billing Manual and the DSM-5-TR serve as key governing texts that dictate clinical documentation standards and prioritize diagnosis and medication in the interest of revenue generation. At the same time, only some of the time spent on this work is reimbursable. The EHR organizes an institutional circuit focused on billing, which is often at odds with patients' embodied lives, experiences, and needs. PMHNPs must then mediate between this ruling relation and what they know patients need. This study contributes to the literature on the social organization of mental health care in support of advocating for policy reforms that recognize the comprehensive needs of individuals with serious mental illnesses.

La continuité des soins, où en sommes-nous en 2025 ?

RECA, M. ET MARSILI, M.

2025

L'information psychiatrique 101(7): 471-473.

https://doi.org/10.1684/ipe.2025.2911

La continuité des soins, un levier pour un moindre recours à la coercition. Enseignements de l'étude PLAID-Care

ROHR, L.

2025

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L'étude PLAID-Care met en lumière le rôle essentiel de la continuité des soins en psychiatrie comme rempart à la coercition. L'intégration de ses multiples dimensions nourrit un lien persistant entre les acteurs du soin et le patient, socle de l'alliance thérapeutique. Si la continuité relationnelle, informationnelle, temporelle et organisationnelle fluidifie et harmonise le parcours de soins du patient, sa fragilité demeure un défi constant pour une pratique respectueuse des libertés individuelles.

Le temps (dé)compté de l'hôpital psychiatrique aujourd'hui.

SARAGA, M.

2025

L'information psychiatrique 101(7): 537-542.

https://doi.org/10.1684/ipe.2025.2921

L'hôpital psychiatrique moderne est né de la fermeture des asiles, caractérisée entre autres par une diminution massive du nombre de lits. On a moins relevé que cette diminution s'est poursuivie sans discontinuer depuis cette rupture avec le modèle asilaire. Ce mouvement s'inscrit dans une critique générale de l'hôpital psychiatrique, fondée sur 5 arguments : diminuer la contrainte, la stigmatisation, l'isolement, la régression et les coûts de la santé. Ce court essai propose une critique en retour de ces discours, en soulignant aussi certaines conséquences néfastes d'une vision aussi négative de l'hôpital.

Les patients et leurs psychiatres. Continuité, politique et ruptures dans la psychiatrie publique en France

TRÉMINE, T.

2025

L'information psychiatrique 101(7): 479-491.

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La continuité des soins est née du rapprochement de la prophylaxie (largement inspirée du modèle nord-américain mais s'inspirant aussi du travail des OPHS [1] contre la tuberculose, l'alcoolisme et les maladies vénériennes) avec les expériences de la guerre. Cette jonction devait se faire en 1945 suivant le modèle de la Sécurité sociale pour rapidement être oubliée par l'État, ses fonctions économique et sécuritaire dominantes. Cela n'empêchait pas les expériences nouvelles mais éparses, dans le 13^{e} arrondissement de Paris et ailleurs. Un long chemin débutait par un travail de désaliénation puis, sous les effets des progrès, la continuité devenait disponibilité, en voulant trop souvent oublier les pathologies psychiatriques au long cours exigeant une prise en charge continue et spécialisée. Dans le monde du « selfhood », la responsabilité devant la maladie passait devant la fragilité. On apprend dans cette histoire de la psychiatrie publique en France que les doctrines dominant les pratiques ne s'imposent pas d'elles-mêmes ; elles collent à l'époque, à son allure générale et à ses nécessités. Elles démarrent comme des « paris », se saisissant des doctrines puisées dans l'ambiance : phénoménologie, psychanalyse, neurosciences et maintenant intelligences artificielles, mais ce sont les savoir-faire qui font les choix.

▶ Longitudinal Network Analysis of Resilience Factors and Mental Health Symptoms Among Healthcare Workers During a Public Health Emergency

ZAINAL, N. H., FOO, C. Y. S., TEO, I., *et al.*

2025

Social Science & Medicine 386: 118653.

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Background Healthcare workers (HCWs) experience various stressors that can adversely weaken mental health and self-perceived resilience, potentially spilling over to compromised patient care. However, the sequela of this phenomenon is not well understood. Therefore, we tested how shifts in resilience factor strength (self-perceived resilience and job dedication) might precede, co-occur, or be a consequence of mental health symptoms among HCWs during a public health emergency. Method A three-wave survey was conducted across two years, each wave about a year apart. HCWs (N = 634) recruited in Singapore self-reported on anxiety and depression symptoms, perceived stress, job dedication, and resilience during each wave. Prospective network analysis determined within-person, cross-lagged temporal relationships between constructs from time t to t + 1, adjusting for autoregressions and other within-person and between-person associations. Results Increased stress predicted future weakened job dedication (Cohen's d = -3.93) and resilience factors (d = -2.96). Likewise, increased depression symptoms predicted subsequent weakened job dedication (d = -0.64) and resilience factors (d = -0.44). Parameter estimates examining resilience factors as a predictor and anxiety symptoms were unstable across the 1,000 network bootstrap iterations. Results remained similar after adjusting for age, sex, chronic illness, social support, being a nurse vs. another HCW, and managerial role status. Discussion HCWs with higher stress and depression severity may experience weaker long-term job dedication and self-perceived resilience, supporting the scar theory and not the vulnerability model of mental health. Interventions targeting high-stress occupations might benefit from focusing on alleviating mental health problems before building resilience.

▶ Depression trajectories from mid to late life (50–89 Years): The roles of cohort, multimorbidity status, and national contexts across nine European countries

ZHANG, Y. ET MA, Z.

2025

Social Science & Medicine 385: 118605.

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Objectives This study aims to disentangle the age and cohort effects on depressive symptoms among middle-aged and older adults, while accounting for the role of multimorbidity across nine European countries. Methods Using longitudinal data from the Survey of Health, Ageing, and Retirement in Europe (SHARE) (2004–2022), with participants aged 50–89 and birth cohorts from 1921 to 1970, we employed Hierarchical Age-Period-Cohort (HAPC)-Growth Curve models to estimate age and cohort effects on depressive symptoms. Interaction effects of multimorbidity and country with cohort and age were also tested. Bounding analysis was used as a robustness check. Results The age effect revealed a U-shaped trajectory of depressive symptoms, with a decline after age 50, reaching a low point around age 65, followed by a sharp increase after age 70. The cohort effect showed that later-born cohorts experienced higher levels of depression. Bounding analysis confirmed these findings: period effects were near zero, with the exception of Spain. Multimorbidity was positively associated with depression, with significant national differences. Younger cohorts with multimorbidity status in Scandinavian countries show elevated depressive symptoms. For

Spain, depressive symptoms are concentrated among earlier-born cohorts. Central European countries showed variability, but Germany's depression trajectory remained stable, with cohort effects being most pronounced. Discussion Our findings emphasize the need for a life-course perspective to understand depression trajectories. Cohort differences highlight the role of sociohistorical contexts, while multimorbidity requires attention in long-term healthcare policy.

From disorder to distress: Investigating neighborhood change and mental health with Streetview and longitudinal survey data

ZHANG, Y. ET MIAO, J.

2025

Soc Sci Med 384: 118589.

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Neighborhood physical disorder, a prominent negative aspect of the residential environment, is expected to adversely affect mental health. However, the limited use of longitudinal designs with objective measures of physical disorder hinders the establishment of causal effects and the generalizability of findings, particularly in rapidly changing urban contexts. This study integrates Streetview data with the Shanghai Urban Neighborhood Survey from 2017 to 2019 to examine changes in physical disorder and their association with psychological distress in Shanghai. Analysis of Streetview data reveals a decline in physical disorder over the study period. Employing fixed-effects models and generalized propensity score matching, we find that this decline is associated with reduced psychological distress. The association is significant among residents with lower socioeconomic status (SES), while it is less pronounced among high-SES residents. These findings contribute to the understanding of the effect of physical disorder by providing more robust evidence from a rapidly transforming urban context. They also shed light on the effectiveness of residential environment improvements in Shanghai and other cities experiencing rapid neighborhood change.

Sociologie de la santé

Sociology of Health

Les conditions de vie des étudiant·es : pauvreté(s), précarité(s) et vulnérabilité(s)

CASEAU, A. C., MOFAKHAMI, M. ET ROSSIGNOL-BRUNET, M.

2025

Revue française des affaires sociales 252(2): 364.

Mise en avant par les médias durant la crise sanitaire de 2020, la précarité étudiante, question désormais centrale, est néanmoins difficile à cerner. En effet, la condition étudiante est par définition transitoire et ses contours sont incertains dans le temps et dans l'espace. Elle se caractérise par une grande hétérogénéité des parcours et des ressources dont la mesure dépend de la prise en compte, délicate, de la « cohabitation » au domicile avec ses parents. Face à ce constat, la RFAS a encouragé une approche multidimensionnelle afin d'enrichir nos connaissances sur la condition étudiante, mobilisant, en plus de la notion de précarité, celles de pauvreté et de vulnérabilité, notions qui peuvent dialoguer voire se croiser, et appelant à des contributions se rapportant aussi bien à la santé, à l'alimentation, à l'isolement, qu'à la nationalité ou encore au logement. Ce dossier se compose de huit articles rassemblés selon trois axes : « statuts, définitions et enjeux méthodologiques », « inégalités sociales et territoriales » et « dimensions de la vulnérabilité ». Ils sont complétés par deux entretiens et quatre points de vue qui traitent, entre autres, des enjeux et limites des mesures de pauvreté et précarité dans la statistique publique, de la précarité administrative, des violences sexistes et sexuelles en contexte universitaire, des étudiants ultramarins.

The social uses of the body

BOLTANSKI, L.

2025

Social Science & Medicine 385: 118141.

https://doi.org/10.1016/j.socscimed.2025.118141

Savoirs expérientiels en santé : revue systématique de littérature

BRETON, H.

2025

Santé Publique 37(3): 241-251.

https://doi.org 10.3917/spub.255.0241

L'énoncé savoir expérientiel en santé désigne une catégorie de ressources forgées par les patients au contact de la maladie, à l'épreuve de l'expérience de la vulnérabilité. Deux enjeux guident cette étude : analyser de manière longitudinale la diffusion du terme, d'abord en sciences humaines et sociales puis dans le domaine de la santé ; et cartographier les terrains de recherche et les domaines d'application identifiés dans la littérature scientifique. Cette démarche permet d'analyser les ancrages disciplinaires et théoriques à partir desquels s'organisent les régimes de validité du savoir expérientiel en santé, dans les pratiques et les recherches.

Luc Boltanski, Pierre Bourdieu, class, capital and the body

COLLYER, F. M.

2025

Social Science & Medicine 385: 118144.

https://doi.org/10.1016/j.socscimed.2025.118144

Transidentité et travail du sexe : dynamiques sociales et enjeux de santé. Troisième partie : Le travail du sexe

D'AUGÈRES, M. B. ET CHARLES, R.

2025

Médecine Vol. 21(6): 263-268.

https://doi.org/10.1684/med.2025.1110

Cette monographie explore les vies de trois personnes transgenres engagées dans le travail du sexe (TDS). Autour de ces entretiens semi-dirigés, l'étude met en évidence des problématiques médicales et sociales multiples, notamment des difficultés d'accès aux soins, les stigmatisations et les préjugés professionnels. Cette troisième partie appelle à une sensibilisation accrue, à la lutte contre les discriminations et à la mise en place de politiques inclusives afin de garantir un accès aux soins respectueux et sécurisé pour les personnes trans travailleuses du sexe.

A toolbox for studying health inequalities: commentary on 'The social uses of the body'

DARMON, M., BAJOS, N., KELLY-IRVING, M., *et al.*

2025

Social Science & Medicine 385: 118142.

https://doi.org/10.1016/j.socscimed.2025.118142

The patient double bind: Seeking outsiders while creating insiders.

SATTERSTROM, P., DEMENTYEV, F., DANEHEY, M., *et al.*

2025

Social Science & Medicine 383: 118375.

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Including patients and their ideas is critical for helping organizations better serve patients. Yet patient partners are often tokenized, which limits the scope and impact of their contributions. In this 23-month longitudinal inductive study of patient participation in multidisciplinary healthcare change teams in three outpatient clinics, we explore the microprocesses that impact patient contributions and the teams' responses to them. We selected a healthcare organization that was committed to using best practices and evidence-based methodologies when designing, launching, and supporting multidisciplinary teams that included patients and aimed to create more patient-centered clinics. To understand how patients contributed and how their contributions were received by the team, we followed patient-team interactions throughout 142 meetings – supplemented with observations, interviews, and archival data. We observed that, while teams welcomed patients, the patients faced recurring cycles of marginalization, narrowing, and redefining what it means to be a patient member of the team. When patients contributed like staff team members or provided convergent incremental patient perspectives on staff-centered projects, their contributions were more likely to be accepted; whereas when patient contributions diverged–challenged and/or offered alternatives to staff assumptions, priorities, and processes–they faced resistance. We mapped three pathways for patients: 1. Empowerment to Exit, 2. Empowerment to Acceptance, and 3. Team Reframing to Patient Adaptation. By delving into how well-intentioned interactions reshaped patient contributions, we develop new theory to better understand how patients and staff may be limited in their ability/mindset to become more patient-centered.

Soins de santé primaires

Primary Healthcare

How is power reflected in the patient centred care literature? A critical review of power in the centredness literature through a social science lens

ADVOCAT, J., STURGISS, E., VADESZ, D., *et al.*

2025

Social Science & Medicine 384: 118560.

https://doi.org/10.1016/j.socscimed.2025.118560

Patient-centredness is a key component of high-quality healthcare. A critical part of centredness is the sharing of power within the practitioner-patient relationship. Yet, there has been little reflection on how power, shared power and empowerment are reflected in healthcare literature about centredness. Our aim was to identify definitions and understanding of power in the healthcare literature on centredness and critically examine these discourses through the framing device of the “faces of power”. A total of 159 papers from a published scoping review on centredness (REF blinded for review) were reviewed for any mention of power. A subset of 46 papers that used the words “power” or “empowerment” were analysed using discourse analysis. Analysis paid detailed attention to the meaning and function of statements in the contexts they occurred to understand taken-for-granted ideas about power in the centredness literature. While power was rarely explicitly defined, ‘sharing power’ was central to the notion of patient centred care. When power was defined it was often conceived as something that clinicians have and can give to patients and then they will make the “right” choice. The literature outlines strategies and consequences of sharing power and barriers and consequences of not sharing power. This work reflects on what is meant when the terms ‘power’ and ‘sharing power’ are used and it aims to start a discussion that goes beyond outcomes, toward reimagining clinician-patient relationships.

Impact of Community Health Center Losses on County-Level Mortality: A Natural Experiment in the United States, 2011-2019

BASU, S., PHILLIPS, R. ET HOANG, H.

2025

Health Serv Res 60(5): e14648.

https://doi.org/10.1111/1475-6773.14648

OBJECTIVE: To estimate the effect of Community Health Center (CHC) site losses on county-level mortality rates. STUDY SETTING AND DESIGN: We conducted a natural experiment study using difference-in-differences analysis of propensity score-matched US counties from 2011 through 2019. DATA SOURCES AND ANALYTIC SAMPLE: The study included 3142 US counties, with 177 counties experiencing CHC site losses in 2014, per data from the health resources and services administration. PRINCIPAL FINDINGS: Loss of CHC sites was associated with an increase in age-adjusted all-cause mortality of 3.54 deaths per 100 000 population (95% CI: 1.19, 5.90; p = 0.003) in the year following the loss. The largest increase was observed for cancer mortality (2.61 per 100 000; 95% CI: 0.59, 4.62; p = 0.011). Primary care physician density and patient volume loss both mediated the relationship. CONCLUSIONS: CHC site losses were associated with increases in mortality. Preserving CHC access may be important for maintaining population health, particularly in underserved areas.

Can multidisciplinary teams improve the quality of primary care? A scoping review

BATES, S. M., LIN, J., ALLEN, L. N., *et al.*

2025

eClinicalMedicine 88: 103497.

https://doi.org/10.1016/j.eclinm.2025.103497

Summary Background There is increasing use of multi-disciplinary teams (MDT) to increase the quality of and access to primary care. For example, the promotion of MDTs in primary care is one of four recent major policy recommendations in Australia. This review sought to understand the impact of MDT on the quality of primary care, including continuity of care, and the enablers and barriers to implementation. Methods A scoping review was undertaken of peer-reviewed journal articles published between 1 January 2014 and 13 August 2024. It is registered at OSF: DOI:10.17605/OSF.IO/23QYU. A search of PubMed, Cochrane, Embase, CINAHL, PAIS, Web of Science, PsycINFO, and Scopus databases yielded 1603 records or 770 articles after duplicates were removed; 75 full-texts were reviewed and 27 studies met the inclusion criteria. The search was repeated for the period 13 August 2024 to 13 August 2025, which yielded a further 282 records after duplicates were removed; 19 full-texts were reviewed and an additional 12 papers met the inclusion criteria reflecting the increasing interest in MDT-care in primary care reforms. Data extracted from the 39 papers in scope included the characteristics of MDT care reported, the outcomes observed, and the enablers and barriers to implementation. A socio-ecological model was used to examine the system, organisational, professional and patient level factors that enabled MDT-care in general practice. Findings Data showed the models of MDT-care varied substantially. They ranged from multiple providers working together to care for a patient, to interprofessional teams providing patients the option to see an alternative provider. Analysis showed mixed outcomes from MDTs in primary care, driven by contextual, policy, organisational, professional and patient factors. In some cases, MDT strengthened the management of chronic disease. In other cases, MDT reduced continuity of care by fragmenting relational continuity. MDT care also impacted access to care, comprehensiveness of care, and coordination of care—in some cases positively, and other cases negatively. Interpretation While there may be common preconditions at the systems, organisational, professional and patient level, effective MDT-care was likely to be goal and context specific. The introduction of MDTs will require careful planning and implementation to ensure that the potential benefits of MDT are realised and that it does not compromise the quality of primary care. Funding The International Centre for Future Health Systems is supported by funding from The Ian Potter Foundation.

▶ A Scoping Review Mapping Economic Evaluations of Midwifery Service Provision and the Midwifery Workforce

CALVERT, B., HOMER, C. S. E., BAR-ZEEV, S., *et al.*

2025

Applied Health Economics and Health Policy 23(5): 823-840.

https://doi.org/10.1007/s40258-025-00962-z

Midwives are essential in achieving universal health coverage targets and the health targets of the Sustainable Development Goals, yet a significant global shortfall exists in the midwifery workforce. Economic evaluations of midwifery are scarce but can assist in supporting evidence-informed decision-making for sustainable and equitable health care for women and girls.

▶ Family physicians' power and team-based care: Lessons from a 60-year-old primary care clinic

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

2025

Social Science & Medicine 383: 118248.

https://doi.org/10.1016/j.socscimed.2025.118248

The article focuses on the tension between team-based care approaches that emphasize interprofessional collaboration and existing power imbalances between family physicians and other health care providers. It contributes to the literature on the implementation of team-based care models in primary care clinics by adopting a governance perspective, often overlooked in these transitions. While existing research has acknowledged power imbalances between family physicians and other health care providers, it has paid less attention to how governance mechanisms may shape these dynamics. Through an in-depth case study of a 60-year-old Canadian primary care co-operative, we address this gap and explore how these power issues play out in a context of collaborative governance and shared decision-making. The methodology is qualitative, relying mainly on data from 42 interviews, as well as on observations and document analysis. On the one hand, the research reveals that some governance mechanisms play an important role in team-based primary care settings, helping attenuate the tension and facilitating collaboration between providers. On the other hand, it shows that, even in a long-standing team-based care model promoting equality between health care professionals and between providers and patients, power imbalances persist. The research illustrates the cultural anchorage of medical domination, highlighting (i) the importance of looking at one organisation's informal norms and cultural context when implementing team-based approaches to care, as well as (ii) the critical need for interprofessional education to actively engage with and address the underlying power dynamics that exist within health care settings.

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

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

2025

Health Policy 163: 105476.

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

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

A scoping review of community participation in public health research and action during the COVID-19 pandemic: Exploring approaches on the continuum between utilitarianism and empowerment

FRAHSA, A., LIWANAG, H. J., KOBLER BETANCOURT, C., *et al.*

2025

Social Science & Medicine 385: 118556.

https://doi.org/10.1016/j.socscimed.2025.118556

ABSTRACT Community participation played a crucial role in addressing health inequities during the COVID-19 pandemic, particularly in reaching marginalized populations and fostering resilience. Amid the wide variation of participatory approaches in community health—from information dissemination to co-decision-making—, there remains a lack of comprehensive analysis on their implementation, impact, and effectiveness. This scoping review synthesizes participatory approaches used during the pandemic, addressing three key gaps: (1) the depth and breadth of participation, (2) the types of communities engaged and the public health issues addressed, and (3) the impact of participation on community health. Following the Joanna Briggs Institute (JBI) methodology, we systematically searched nine bibliographic databases, identifying 20,672 records. After removing duplicates and screening articles based on predefined inclusion criteria, we included 127 studies. Our analysis included mapping participation depth using Arnstein's ladder, categorizing motivations as utilitarian or emancipatory, and identifying the types of communities engaged and the community health issues addressed. We also examined community health outcomes and developed a conceptual heuristic framework to better characterize participatory approaches. Based on our findings, we propose eight key recommendations for improving the implementation and reporting of participatory approaches in community health. These include providing clear definitions of community and community health, ensuring transparency in participation levels and phases, elaborating on participatory methods, avoiding (re)stigmatization, and promoting community-driven research and action. By enhancing participatory practice and evaluation, these recommendations can support more equitable, effective, and sustainable community health interventions in pandemic contexts and beyond.

Employment Models for General Practitioners in England: Evidence from Repeated Surveys

GIBSON, J. M., URWIN, S., SPOONER, S., *et al.*

2025

Health Policy 161: 105425.

https://doi.org/10.1016/j.healthpol.2025.105425

Background Recruitment and retention of General Practitioners (GPs) is a global challenge in primary care. Traditionally, GPs in the UK have worked as self-employed partners. However, policy changes in England have allowed for salaried GP positions within primary care partnerships. The effects of these different employment models on recruitment and retention remain unclear. Objective This study investigates the impact of partnership vs. salaried employment models on GP job satisfaction, job pressures, and intentions to

reduce working hours in England. Methods Data from nine waves of the national GP Worklife Survey (2001-2019) were analysed using multivariate regression models. The analysis adjusted for several GP characteristics, including age, gender, ethnicity, marital status, and number of children. Results Salaried GPs reported higher satisfaction with working hours but lower satisfaction with income compared to partner GPs. Partner GPs experienced higher job pressures and were more likely to intend to reduce their working hours within five years. Conclusions Flexible working arrangements, such as salaried positions, may enhance job satisfaction and retention among GPs, helping to address workforce challenges in primary care. Targeted policies are needed to mitigate job pressures and improve satisfaction, particularly among partner GPs.

▶ Prescribing power and equitable access to care: Evidence from pharmacists in Ontario, Canada

HOAGLAND, A. ET WANG, G.

2025

Journal of Health Economics 103: 103051.

https://doi.org/10.1016/j.jhealeco.2025.103051

Allowing pharmacists to directly treat patients may increase equitable access to healthcare and improve patient outcomes, but raises concerns about supply-side moral hazard or patient substitution away from regular physician-based care. We study the effects of a 2023 policy allowing pharmacists to prescribe for minor ailments in Ontario, Canada. We use Advan foot traffic data to measure how this policy affected visits to pharmacies and generated spillover effects on visits to non-pharmacy medical facilities (Research, 2022). Allowing pharmacists to prescribe led to a 16% increase in total visits to pharmacies and a 3% increase in visits to other providers. These increases were concentrated in materially deprived neighborhoods and benefited non-minority, non-immigrant populations the most. We use the policy as exogenous variation to identify substitution elasticities between pharmacy visits and traffic to other medical facilities. Overall, 20% of the increase in traffic to pharmacies spills over into increased use of outpatient-based care. Pharmacy traffic is a substitute for visits to hospitals and emergency departments, potentially as patients rely on pharmacists for triaging rather than emergency care.

▶ The moral dimension of professional socialization in the premedical years

HOXHA, K. ET VINSON, A. H.

2025

Social Science & Medicine 384: 118561.

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Recent medical sociology scholarship has highlighted the importance of the premedical years for shaping students' career expectations and trajectories. We advance research on professional socialization in the premedical years by elucidating its moral dimension through an investigation of how students prepare to take situational judgment tests, an application requirement introduced in the United States over the past ten years. These tests present students with challenging scenarios that often contain a moral dilemma. Drawing on qualitative analysis of online forum discussions of test scenarios (12 scenarios and 150 comments), we describe how premedical students negotiate the medical profession's expectations of them as moral actors. We find that students collectively negotiate the appropriateness of test responses in online forum discussions. Premedical students draw distinctions between how they would respond to test scenarios versus act "in real life" and attempt to collectively figure out what types of responses will help medical schools perceive them as good future doctors. Students also display frustration at the position such tests ask them to take vis-à-vis scenarios that present social problems or ask them to adhere to organizational policies or rules that students find to be overly interventionist. Our findings highlight the moral dimension of professional socialization, bringing sociology of health professions education into conversation with recent work on the sociology of morality.

▶ Emergency Department Crowding: How Valuable is GPs Information?

LEVAGGI, R., MARCHIORI, C., MARCHIORI, M., *et al.*

2025

Social Science & Medicine 385: 118600.

https://doi.org/10.1016/j.socscimed.2025.118600

The paper contributes to the literature on overcrowding in Emergency Departments (EDs) by providing an empirical estimation of the effectiveness of a GP's referral in reducing the inappropriate use of EDs. This was made possible thanks to a unique dataset of admission records taken in the province of Trento, which contains, among other things, specific information on how the decision was made to visit the ED (i.e., was it the patient's own decision or was the visit based on the advice of their GP). In our estimation sample, 10.5% of the accesses are inappropriate but we find that GP referrals reduce the probability of inappropriate access by 6.5 percentage points on average; the results are robust to changes in parameters and estimation models. From a policy perspective, the analysis suggests that GPs could play a crucial role in reducing overcrowding in EDs and provides quantitative support for the use of fast-tracking GP referrals as a possible management strategy.

Value-Based Payments Associated With Improved Quality Of Care At Federally Qualified Health Centers, 2014–23

LI, K., KWON, K. N., MARKUS, A., *et al.*

2025

Health Affairs 44(11): 1404-1410.

https://doi.org/10.1377/hlthaff.2025.00483

Recent federal and state policies have been facilitating the participation of federally qualified health centers (FQHCs) in value-based payment programs to transform care delivery for underserved populations. However, evidence regarding FQHCs' value-based payment revenue and its relationship with the quality of care is limited. Using administrative data from all FQHCs in the US, we assessed trends in the centers' value-based payment and capitation revenue penetration during the period 2014–23 and examined the associations of quality outcomes with the receipt of these revenues. Although value-based payment and capitation revenue penetration increased over time, only 51.2 percent of FQHCs received value-based payment and 34.1 percent received capitation payment in 2023, accounting for an average of 2.4 percent and 9.4 percent of patient revenue, respectively. Receiving value-based payment was associated with increased levels in seven of nine quality measures relevant to preventive and primary care. Our findings suggested potential quality improvement effects of value-based payment, although barriers for FQHCs to participating in these programs may still exist.

Impact of primary care market mergers on quality: Evidence from the English NHS

LYU, Y. ET ZHANG, Z.

2025

J Health Econ 104: 103050.

https://doi.org/10.1016/j.jhealeco.2025.103050

The primary care market has experienced a growing trend of provider consolidation through mergers and acquisitions, yet the implications of this concentration remain unclear. This study addresses this gap by providing the first empirical evidence on the effects of provider mergers on quality, using evidence from the English primary care market. Examining all provider mergers from 2014 to 2018, we find that mergers improve certain aspects of clinical quality management, but they do not translate into broader population-level clinical quality gains, and patient satisfaction declines significantly. Importantly, the effects vary by merger motivation and the size of the merging parties, rather than their geographic proximity. Survival-driven mergers help sustain care quality and patient access, whereas efficiency-driven mergers lead to greater quality deterioration. Mergers between larger practices also lead to more negative outcomes than those involving smaller practices. In contrast, we find no significant difference between within-market and cross-market mergers. An exploration of the mechanism reveals that changes in market concentration do not explain the observed quality outcomes. Instead, shifts in workforce composition, driven by the underlying merger motivations, play a key role.

New forms of expertise and their implications for the system of professions in healthcare: the case of the patient safety specialist role in the English NHS

MARTIN, G. P., PRALAT, R., WARING, J., *et al.*

2025

Soc Sci Med 385: 118562.

https://doi.org/10.1016/j.socscimed.2025.118562

Contemporary societal shifts are disrupting established professional divisions of labour in healthcare. Some have argued that professionalism itself is being transformed, with professions characterised less by claims to exclusive jurisdiction and more by connectivity and complementarity. This article puts these arguments to the test in a domain traditionally characterised as one of professional conflict: patient safety. Informed by the sociology of expertise, we consider the case of a new role-the patient safety specialist-constructed by some as a profession in the making. Drawing on three qualitative datasets comprising interview and focus group contributions from 71 participants, we find that patient safety specialists struggled to establish the legitimacy of their expertise in organisational environments that were often hostile. By forging alignments with the interests of clinical professionals, however, some advanced their roles in ways that served mutual interests, in line with recent theses on the changing nature of professionalism and the need for expertise that connects increasingly interdependent jurisdictions. The extent to which this advancement offered a solid and durable foundation for a claim to professional status, however, seemed more questionable.

▶ Can de-budgeting save primary care in Germany? A turning point for general practice

MOHEBBI, D., YASAR, R., ADEMI, A., *et al.*

2025

Health Policy 161: 105426.

https://doi.org/10.1016/j.healthpol.2025.105426

In its last healthcare act, Germany's previous government abolished budget caps for general practitioners (GPs) in February 2025, exempting most primary care services from quantity limits and fee reductions. Originally introduced in 1993 to control healthcare costs, budgets have led to significant financial shortfalls for outpatient practices. Meanwhile, a worsening GP shortage - driven by high retirement rates, changing career preferences, and increasing healthcare demand - has made primary care reform urgent. The new law seeks to make general practice more attractive but does not cover all GP services. Critics warn of financial burdens, with health insurers estimating additional annual costs of euro400 million for GPs. While de-budgeting is a key step, broader reforms - strengthening practice structures, medical education, and digital systems - are needed to secure the future of primary care.

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

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

2025

Health Policy 161: 105415.

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

Background Prescription is a complex act that reflects the physician's expertise and authority. While some factors affecting prescription decisions have been studied, empirical findings often conflict, leaving our understanding of prescription behaviors limited and fragmented. Objective To assess the factors influencing physicians' drug prescribing habits by applying Strong Structuration Theory. Factors are categorized at: physician, practice, patient, industry, and system level. Methods Pubmed, Scopus, and ISI Web of Science were searched from inception to June 2025. Peer-reviewed studies were included if they were published in English, empirical, and assessed at least one factor influencing physicians' prescribing behaviors. Studies reporting the effect of covariates on prescriptions using Odds Ratios were included in the meta-analysis. Results 146 studies were included in the review. At the macro-level, physicians were more likely to prescribe after being exposed to marketing activities by pharmaceutical industries, and for privately insured patients. Meso-level factors, such as practice ownership and setting, showed conflicting results, with no significant effect observed in the meta-analysis. Micro-level influences were the most prevalent in literature. Patient requests had a significant positive effect on prescriptions. Physician-level influences were inconsistent across most variables, except gender, where male physicians were more likely to prescribe. This effect was not confirmed by the meta-analysis, which showed heterogeneity across studies. Conclusion This study highlights the complexity of prescribing behaviors and the challenges in designing effective micro-level policies. Policymakers should therefore consider the multiple influences on prescribing to design targeted interventions that promote rational prescribing practices.

▶ Effet du projet OCTAVE sur les relations interprofessionnelles entre médecins généralistes et pharmaciens d'officine : une étude qualitative

PLASSART, J., HUE, B. ET SOMME, D.

2025

Santé Publique vol. 37(3): 133-143.

https://doi.org/10.3917/spub.pr2.0079

Introduction : Le projet OCTAVE, mené dans des territoires de santé de Bretagne et Pays de la Loire, a pour objectif de sécuriser le parcours médicamenteux des personnes âgées polymédiquées hospitalisées. Cela passe notamment par la réalisation systématique après la sortie d'hospitalisation d'un bilan partagé de médication par le pharmacien d'officine référent du patient, transmis ensuite à son médecin traitant.

La communication entre ces deux professionnels de santé est donc indispensable au bon déroulé des parcours, mais difficilement évaluable en pratique. But de l'étude : Analyser l'effet du projet OCTAVE sur les relations interprofessionnelles entre médecins généralistes et pharmaciens d'officine, à l'issue du parcours de leur patient dans OCTAVE. Méthode : Dans cette étude qualitative, quinze entretiens semi-dirigés ont été réalisés avec des pharmaciens d'officine et médecins généralistes d'Ille-et-Vilaine dont un patient a été inclus dans OCTAVE, entre juin 2023 et janvier 2024. Résultats : Malgré des besoins identifiés et une volonté commune de limiter la iatrogénie médicamenteuse chez leurs patients âgés, le projet OCTAVE n'a pas amené les professionnels à communiquer davantage entre eux. Les pharmaciens d'officine ont pourtant profité de ce projet pour affirmer et valoriser leurs nouvelles missions, dont fait partie le bilan partagé de médication. Mais le manque d'information et d'investissement des médecins généralistes, ainsi que les représentations de chacun sur leurs rôles propres, a constitué un frein évident à une coopération accrue. Conclusion : OCTAVE n'a pas eu d'effet direct sur les relations entre pharmaciens d'officine et médecins généralistes. Des pistes d'amélioration ont été mises en évidence.

▶ Strengthening primary health care: The new contribution of midwives to gynecological care in France

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

2025

Health Policy 161: 105397.

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

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

▶ Réguler la démographie des kinésithérapeutes libéraux : des quotas à l'accessibilité, des instruments qui permettent aux administrations de s'affirmer

ROLLIN, J.

2025

Politix n° 149(1): 163-187.

https://doi.org/10.3917/pox.149.0163

▶ What seems to be "the problem"? Locum doctors, liminality and concerns about performance

STRINGER, G., FERGUSON, J., WALSHE, K., *et al.*

2025

Social Science & Medicine 383: 118489.

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Doctors who work in temporary positions (usually termed locums) in healthcare organisations can occupy a liminal space – at the margins of both the organisation and the medical profession, often situated on the periphery of or even outside formal structures for governance and support and informal professional and social networks. Qualitative semi-structured interviews were conducted with 88 participants including locums, permanently employed doctors, nurses and others with governance and recruitment responsibilities for locums across primary and secondary healthcare organisations in the English NHS during 2021-22. Data was analysed using reflexive thematic analysis and abductive analysis. Three main themes were constructed: i) lack of trust in and 'othering' of locums results in a low tolerance for problems or concerns, and a tendency both to apportion blame to the locum and to escalate concerns into formal processes of scrutiny and review; ii) low level of reciprocity of effort and mutual benefit in relationships between locums and organisations means problems or concerns may remain unresolved despite such processes of review; iii) lack of structural assertions which encompass locums and the organisations where they work may mean that both they and organisations may avoid scrutiny and responsibility for problems which affect the quality and safety of patient care. The liminal space occupied by locum doctors fundamentally shaped the way that narratives about performance concerns were constructed and enacted, in ways that mean the locum doctor was likely to be seen as "the problem". The combined consequences of the forms of liminality experienced by locum doctors – organisational, professional and socio-cultural – have profound implications for these doctors' sense of professional identity as well as for their performance. Organisations should seek to reduce or mitigate liminality to improve not only the quality and safety of patient care but also locum identity and performance.

Les pharmaciens

TABUTEAU, D.

2025

Les Tribunes de la santé N° 84(2): 103p.

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What matters most to the population in case of chronic conditions? Results from a discrete choice experiment in Italy

VAINIERI, M., SPATARO, V., DE ROSIS, S., *et al.*

2025

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Relational continuity, care coordination, and teamwork are widely recognized as key components of quality in primary care. This study investigates population preferences regarding organizational models of primary care, with a particular focus on the roles of general practitioners, specialists, and nurses. A Discrete Choice Experiment (DCE) was conducted through a nationwide online cross-sectional survey, employing a full factorial experimental design with 20 randomly selected choice sets to minimize cognitive burden. The attributes examined included coordination, relational continuity, and teamwork. Data were collected from a representative sample of 2,553 respondents across Italy in early 2021. Results underscore the centrality of teamwork (OR=1.85 in mild and 2.31 in severe chronic conditions), followed by relational continuity (OR=1.60 in mild and 1.55 in severe conditions). Coordination ranks third (OR=1.31) for mild conditions but reaches parity with relational continuity in the context of severe chronic conditions. These findings offer robust evidence of differentiated preferences based on chronic disease severity and support the design of tailored primary care models. In conclusion, this analysis highlights the importance of incorporating coordination, relational continuity, and teamwork in the configuration of primary care services, offering policy-relevant insights for adapting delivery models to the needs of patients with varying levels of chronicity.

A good rest makes a caring doctor: Linking physicians' nonwork time recovery to patient-centered communication with nonwork-to-work enrichment and empathy

ZHENG, Y., YANG, S., LI, Q., *et al.*

2025

Social Science & Medicine 383: 118432.

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As an ideal form of patient-physician communication, patient-centered communication (PCC) is linked with various desired health and relationship outcomes, raising the need to promote PCC practices among physicians. However, how factors within physicians' daily work and life contexts are associated with PCC remains largely unknown. Based on the work-home resource (PCC) model, we proposed and tested a mediation path model linking nonwork time recovery—the restoration of resources during leisure time—to physicians' PCC. This study has revealed that nonwork time recovery was indirectly and positively associated with PCC by analyzing quota-sampled data collected among physicians. The association is drawn by 1) the sequential mediation of nonwork-to-work enrichment (NWE), 2) the transfer of instrumental and affective resources from nonwork to work domain, and 3) two dimensions of empathy, i.e., perspective-taking as the cognitive dimension and empathetic concern as the affective dimension. This study contributes to the patient-physician communication literature by revealing the mechanism of how work-nonwork synergy may benefit high-quality patient-physician communication from a resource-based perspective.

Systèmes de santé

Health Systems

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

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

2025

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

Impacts of social determinants on the transient and persistent inefficiency of health systems in OECD countries

EFECAN, E. Ö. ET EFECAN, V.

2025

Health Policy 161: 105433.

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This study examines the impact of social determinants on the transient and persistent technical inefficiency of health systems in OECD countries between 2010 and 2020. To estimate inefficiency, panel efficiency models—True Random Effects (TRE) and Generalised True Random Effects (GTRE) models—are employed. The results reveal that the overall inefficiency of OECD countries is largely attributable to long-term policies. Furthermore, transient inefficiency increases, on average, by 1.6 % for every 1 % increase in the unemployment rate, while persistent inefficiency increases, on average, by 6.8 % for every 1 % increase in income inequality. To enhance the long-term efficiency of health systems, governments should address unemployment, education and income inequality. This study represents the first cross-country evaluation to consider unemployment, education, income inequality, and population as social determinants of health system efficiency, employing two competing stochastic frontier models at the country level.

Implementing integrated care infrastructure: A longitudinal study on the interplay of policies, interorganizational arrangements and interoperability in NHS England

ELIZONDO, A., WILLIAMS, R., ANDERSON, S., *et al.*

2024

Health Policy: 105237.

https://doi.org/10.1016/j.healthpol.2024.105237

BACKGROUND: New models of care that integrate health and social care provision around the patient require a supportive infrastructure, including interorganizational arrangements and information systems. While public policies have been designed to facilitate visions of integrated care, these often neglect the implementation of effective and efficient delivery mechanisms. METHOD: This study examines a decade of attempts to move from fragmented health and care delivery to integrated care at scale in NHS England by developing and implementing a support infrastructure. We undertook a longitudinal qualitative investigation -encompassing interviews and documentary analysis- of the implementation of interorganizational and digital interoperability infrastructures intended to support integrated care policies. FINDINGS: Our findings underscore the long-term symbiotic relationship between institutional interorganizational frameworks and the construction of interoperability infrastructures, emphasizing how they mutually reinforce each other to support their ongoing evolution. Iterative, flexible, and experimental approaches to implementation provide opportunities to adapt to local realities while learning in the making. CONCLUSION: This study underlines the importance of adaptable, locally-informed implementation strategies in supporting the vision of integrated care, and the need to understand such development as a long-term, ongoing process of construction and learning.

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

HIILAMO, A.

2025

Social Science & Medicine: 118630.

https://doi.org/10.1016/j.socscimed.2025.118630

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

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

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

2025

Health Policy 162: 105441.

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BACKGROUND: There has been a growing concern over rising medical interventions during childbirth, particularly caesarean sections, without corresponding improvements in maternal or neonatal outcomes. Midwifery-led units (MLUs) offer a model that promotes physiological birth while reducing unnecessary interventions. In Spain, where maternity care is predominantly hospital-based and obstetrician-led, the first public MLU opened in Catalonia in 2017. Its temporary closure after five years offers a unique opportunity to assess its impact on interventions and outcomes. OBJECTIVE: To evaluate the MLU's implementation and its effect on childbirth interventions within the unit and across the host hospital. METHODS: A retrospective cross-sectional trend study of childbirth data (2018-2023) from all public Catalan hospitals, and a retrospective cohort study of women contacting the MLU (2017-2022). RESULTS: MLU demand tripled between 2018 and 2022. Among 1286 attendees, 64.8% were nulliparous and predominantly had low risk pregnancies. Half who planned an MLU birth began labour there, achieving 92.3% spontaneous vaginal births and 4.1% caesareans. Hospital-wide, caesarean rates fell from 23.5% to 13.5% (2019-2021), while spontaneous births rose to 78.7%, suggesting a spill-over effect beyond the MLU. These trends reversed after closure in 2022. CONCLUSION: Spain's first public MLU was successfully implemented, safely reducing interventions and influencing wider hospital practices. Its closure and subsequent regression in birth outcomes highlight the need for sustained support and investment. MLUs can be an effective strategy for lowering intervention rates in highly medicalised systems, benefiting both unit users and the broader maternity care environment.

Measuring health system resilience: Understanding the relationship between excess mortality and health system performance.

PAPANICOLAS, I. ET LEDESMA, J.

2025

Health Policy 161: 105430.

https://doi.org/10.1016/j.healthpol.2025.105430

Background The COVID-19 pandemic has underscored the importance of resilient health systems that can manage and adapt to large-scale health crises. However, the relationship between resilience and health system performance remains unclear. While some view performance as a feature of resilience, others conflate the two. Excess mortality—defined as the difference between observed and expected deaths during a given period—is often used to assess resilience, but may introduce bias. In particular, countries with stronger pre-pandemic performance and lower baseline mortality may appear to have worse resilience simply because they had less “room” for mortality to rise under normal conditions. Objective This study examines the relationship between pre-pandemic health system performance and resilience, as measured by excess mortality during the first two years of COVID-19. Methods Using the Healthcare Access and Quality (HAQ) Index, we evaluate baseline performance across 194 countries and compare it to age-standardized excess mortality from three major sources. Results Our analysis shows that health systems with higher pre-pandemic HAQ scores generally experienced lower excess mortality, though the strength of this association varied by data source and was most consistent in the second year of the pandemic. Adjusting for baseline performance using a normalized threshold of pre-pandemic performance, rather than country-specific baselines, improved comparability of excess mortality across countries. Conclusions These findings suggest that higher baseline performance may enhance resilience to health crises, and that normalizing baselines could yield more accurate cross-country resilience assessments.

The Contribution of Health and Health Systems to other Sustainable Development Goals. An Overview of the Evidence on Co-benefits

SICILIANI, L. ET CYLUS, J.

2025

Health Policy 162: 105454.

https://doi.org/10.1016/j.healthpol.2025.105454

Background While the effects of other sectors on health outcomes have been recognised, the co-benefits that arise from health or health systems to other sectors have received far less attention. Objective This study summarizes findings from a special issue in Health Policy documenting evidence of co-benefits from health and health systems to other Sustainable Development Goals: poverty, education, work and economic growth, gender equality, reducing inequalities, responsible meat consumption, climate action, and strong institutions. Methods After providing a conceptual framework, we summarise evidence on co-benefits from the nine articles of the special issue, which were written as narrative reviews. Results The articles generally find strong evidence of co-benefits from health and health systems to other SDGs. Positive effects of health and health systems were consistently found for education and labour market outcomes, both of which contribute to poverty reduction. Health contributes towards better and inclusive institutions by promoting social capital, political participation and supporting peace. Improved maternal, reproductive, and sexual health lead to enhanced labour participation and educational investment among women. Health system financing has redistributive properties which can serve to reduce inequalities. Health effects on macroeconomic growth were more difficult to establish empirically, though recent evidence is supportive. Health and health systems can also generate environmental co-benefits. Green interventions can reduce carbon footprint of health care. Promotion of healthy behaviours that reduce meat consumption can generate environmental co-benefits through their impact on climate, biodiversity, water use and pollution. Conclusions Overall, this evidence suggests that investing in health contributes to achieving other societal goals.

Cumulative Legacies and Crisis Decision-Making in Shocks to the Irish Health System: A Mixed Methods Analysis

THOMAS, S., O'DONOGHUE, C., ALMIRALL-SANCHEZ, A., *et al.*

2025

Health Policy 161: 105432.

https://doi.org/10.1016/j.healthpol.2025.105432

Background Shocks, and the responses to them, always leave behind a legacy. In situations of sequential shocks or even permacrisis the legacy can become cumulative. It is therefore vital for decision-makers in a crisis to understand that their decisions will have long-lasting implications for health system performance and resilience. Objective In this article the authors explore the nature of legacy and a shock cycle approach to health system resilience. We investigate the case study of the Irish health system, which has undergone several shocks in succession, from economic austerity to COVID-19, a cyberattack and the cost-of-living crisis. Methods We explore quantitative health system performance metrics as well as qualitative interviews with health system experts who have been involved in the health system since the economic crisis in order to illuminate learnings around legacy and resilience. The case study is informed by analysis from the PHSSR programme and the PRESTO report. Results The results indicate that key cumulative legacy effects of the shocks in Ireland have been both negative and positive. There have been longer waiting lists, as well as demotivation, turnover and disengagement of staff that has resulted in poorer access to routine care. Yet there have also been successful reform efforts to universalise the health system and expand community-based care. This includes dropping access charges, additional funds to support capacity and democratising decision-making within services. Conclusion Taken together, this analysis highlights the compounding nature of shocks to the health system and their enhancement of both the strengths and weaknesses of health systems.

Corrigendum to "Mitigating the regressivity of private mechanisms of financing healthcare: An Assessment of 29 countries"

WAITZBERG, R., ALLIN, S., GRIGNON, M., *et al.*

2025

Health Policy 161: 105446.

https://doi.org/10.1016/j.healthpol.2025.105446

Travail et santé

Occupational Health

The 'survival job' pathway: Risk-focusing and occupational challenges among Canadian racialized and immigrant adults during the COVID-19 pandemic

KILIUS, E., RISHWORTH, A., SUH, J., *et al.*

2025

Social Science & Medicine 383: 118415.

https://doi.org/10.1016/j.socscimed.2025.118415

The impacts of the COVID-19 pandemic were not equally distributed, with emerging research demonstrating that racialized and immigrant populations in Canada have been disproportionately affected. Drawing on the risk-focusing hypothesis, a theoretical lens that explicates how risk burden concentrates disproportionately in marginalized populations, government mitigation strategies such as shutdowns can be seen as exacerbating existing social and economic challenges, making individuals more susceptible to COVID-19 and its adverse outcomes. This paper examines the economic and occupational challenges experienced by individuals from racialized and/or immigrant populations in the Peel Region (Ontario, Canada) during COVID-19 shutdowns. Semi-structured interviews (n = 46) were conducted from October to December 2021, discussing participants' experiences throughout the pandemic. Using thematic analysis, interviews were coded for concepts related to employment, economics, and government support. Semantic codes were grouped into categories, where themes were identified and refined. Loss of work and difficulties in securing employment were primary themes across interviews, with participants discussing taking on low-skill "survival jobs" to pay the bills. Participants spoke of being worried about finances and decreased mental health as a result. An additional theme was the pathways of risk that accompanied employment. While government economic and social programs were considered helpful, challenges were noted in navigating resources. This study highlights the importance of examining pandemic outcomes from a risk-focusing framework, to understand how certain groups were repeatedly put at risk.

Trajectories of immigrant workers with work-related injuries: the path to mistrust

ARSENAULT, M., WHITE, B. ET CÔTÉ, D.

2025

Social Science & Medicine 385: 118577.

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ABSTRACT In Quebec, injured workers are entitled to medical assistance, wage replacement, and rehabilitation. While many cases are resolved smoothly, ethnographic research reveals that immigrant workers may face disruptions that foster mistrust and hinder recovery. This study examines how mistrust shapes the rehabilitation experiences of immigrant workers and identifies its root causes and impacts. Based on ethnographic observations at a Montreal rehabilitation clinic and 21 in-depth interviews with injured immigrants workers conducted between 2020 and 2024, the research highlights how mistrust emerges from experiences of racism, discrimination, perceived betrayal, employer practices, conflicting medical opinions, and fraudulent behaviors. These factors, often intersecting across institutional systems, contribute to a cumulative burden that impedes recovery and well-being. The findings underscore the need for systemic changes to build trust and improve rehabilitation outcomes for immigrant workers.

Health and Unemployment During a Negative Labor Demand Shock

BRATBERG, E., HOLMÅS, T. H., KJERSTAD, E., *et al.*

2025

Health Economics 34(11): 2114-2139.

https://doi.org/10.1002/hec.70025

ABSTRACT The association between unemployment and health is well documented, but causality remains unclear. This paper investigates how pre-existing health conditions amplify the effects of adverse labor market shocks. Using variation in local unemployment generated by a shock in the petroleum prices that hit the geographic center of the petroleum industry in Norway, but left other regions more or less unaffected, our study reveals that workers with compromised health face a higher likelihood of unemployment during downturns. Heterogeneity analysis reveals differences in susceptibility based on gender, age, education, and job type. Females exhibit greater sensitivity to health, and the youngest age group is most affected. Furthermore, higher education and white-collar jobs correlate with amplified health-related unemployment effects. Conversely, poor health in combination with high age, low education, and blue-collar jobs increases the uptake of social insurance during the economic downturn, pointing toward the substitutability between unemployment benefits and health-related benefits.

Implementing Employability Interventions for Workers with Health Conditions: A Systematic Review

DANIELS, K., FITZHUGH, H. ET NOORAYA, R.

2025

Social Science & Medicine 385: 118597.

https://doi.org/10.1016/j.socscimed.2025.118597

Health conditions are a major source of economic inactivity in working age adults. We conducted a systematic review of eight databases to identify factors that influence the implementation of effective interventions for workers with health conditions. We reviewed 55 separate studies of interventions to improve employment and/or health outcomes for workers or those seeking work. Findings were synthesized into evidence-statements (e.g., “Facilitating governance structures are associated with a) efforts at continuation and adaption of interventions and b) learning structures and activities”). The evidence-statements were synthesized into a theory of change to explain the level of implementation of interventions, employment, health, and work performance outcomes. The theory of change considers factors related to: the employing organization’s external and internal environment (e.g., labor market legislation), intervention management, intervention features, and a range of stakeholders (e.g., intervention recipients, line managers, health professionals). We identified gaps in the literature, including knowledge of how implementation factors relate to cost-effectiveness and knowledge on how interventions and organizations are adapted to fit with each other. This systematic review is registered on PROSPERO (CRD42024591723).

The Effects of Parental Unemployment on Children's Wellbeing – Results from Switzerland and the United Kingdom

MARIANO, C., HENKING, C., GONDEK, D., *et al.*
2025

Social Science & Medicine 385: 118609.

https://doi.org/10.1016/j.socscimed.2025.118609

Abstract: Objective This study uses longitudinal panel data from Switzerland and the United Kingdom to examine how parental unemployment at year T affects children's wellbeing at year T+2 through parental wellbeing at year T+1. We also test the moderating effects of unemployment benefits, wealth, and household composition on parental wellbeing. Method We used data from the Swiss Household Panel (1999-2021) and Understanding Society (1991-2022). Wellbeing was measured using life satisfaction and worry in Switzerland, and life satisfaction and psychological distress in the UK. We applied linear mixed-effects models to test moderation between unemployment and parental wellbeing and conducted causal mediation analyses to assess indirect effects of unemployment on child wellbeing through parental wellbeing. Results In Switzerland, household composition and home ownership significantly moderated the relationship between maternal unemployment and life satisfaction. In the UK, unemployment benefits moderated the association between maternal unemployment and psychological distress. Causal mediation analyses using Swiss data revealed that the effect of maternal unemployment on child outcomes was partially mediated by maternal life satisfaction and worry. Paternal unemployment had a direct effect on child life satisfaction. In the UK, results indicated partial mediation through life satisfaction and psychological distress in both mother-child and father-child dyads. Conclusion Our results suggest that parental employment is associated with child wellbeing, and that this association is partially explained by changes in parental wellbeing. These relationships vary across countries depending on family composition, wealth, and access to unemployment benefits.

Meso-organisational determinants of healthcare workers' resilience: results of a scoping review

OPREA, N., GIACOMELLI, G., SARTIRANA, M., *et al.*
2025

Health Policy 161: 105412.

https://doi.org/10.1016/j.healthpol.2025.105412

This scoping review aimed to map and synthesise multidisciplinary evidence on meso-level organisational factors that influence individual resilience among healthcare workers. Specifically, we focused on identifying workplace-related risk and protective factors within the immediate organisational environment.

Effects of Health Shocks on Adult Children's Labor Market Outcomes and Well-Being

RAMIREZ LIZARDI, E., FEVANG, E., RØED, K., *et al.*
2025

Health Economics 34(10): 1804-1820.

https://doi.org/10.1002/hec.70005

ABSTRACT Using Norwegian administrative register data, we assess the impact of unexpected health shocks hitting lone parents on offspring's labor market outcomes and well-being. We use first-time hip fractures or strokes as indicators of parental health shocks and estimate both the overall effects and the heterogeneous impacts by the survival time of the affected parent. We identify small, but significant, immediate responses in terms of an increase in physician-certified sickness absences and a higher risk of diagnosed mental disorders. The short-term effects are larger for offspring whose parents die shortly after the shock. Most of the effects fade out quickly, and the negative impacts on subsequent employment and earnings are small and only borderline statistically significant. In general, our results suggest that the responses to the deteriorating health of a parent tend to be short-lived and mostly manifest as temporary absences from work rather than complete detachment from the labor market.

Vieillissement

Ageing

Home vs. nursing care: Unpacking the impact on health and well-being

BASSOLI, E., LEFEBVRE, M. ET SCHOENMAECKERS, J.

2025

Soc Sci Med 385: 118533.

https://doi.org/10.1016/j.socscimed.2025.118533

In this paper, we present estimates of the effect of different care settings on health and well- being outcomes. We use data from the French CARE Survey, which interviews individuals aged 60 and above, to assess the differential effect of living at home or in a nursing home on mortality, morbidity and well-being indicators. In addition, we differentiate the effect between for-profit and non-profit nursing homes. To do so, we apply a propensity score matching approach that controls for selection on observables by matching people living at home with those living in nursing homes. Our results are threefold. First, we observe a positive effect of being in a nursing home on health outcomes but a negative effect on other well-being indicators such as happiness and nervousness. Second, the ownership status of the nursing home matters and the positive effect is stronger for non-profit and public nursing homes. Third, residents in for-profit nursing homes appear to to be worse off than those in nonprofit institutions. These findings raise important questions for the future organization and the funding of long-term care.

Bidirectional, longitudinal associations between finance and health - what comes first? Evidence from middle-aged and older adults in Europe

BIALOWOLSKI, P., CWYNAR, A. ET WEZIAK-BIALOWOLSKA, D.

2025

Social Science & Medicine 385: 118633.

https://doi.org/10.1016/j.socscimed.2025.118633

This study examines the bidirectional longitudinal relationship between financial conditions and health among middle-aged and older adults in Europe. Using eight waves (2004–2022) of data from the Survey of Health, Ageing and Retirement in Europe (SHARE), we applied a random intercept cross-lagged panel model (RI-CLPM) to assess reciprocal associations over time between multiple subjective and objective financial and health indicators, while accounting for stable individual differences. Results reveal consistent evidence of mutual influence between financial status and health, though the patterns are asymmetric, with effects from health to financial outcomes generally stronger and more robust. Poor mental and functional health, including depressive symptoms and limitations in daily activities, were associated with deteriorating financial outcomes such as reduced net worth, greater debt, and increased financial strain. Conversely, subjective financial strain, more than income or financial assets, predicted later declines in health, particularly in mental well-being and mobility. Mortgage debt and other liabilities were also consistently associated with poorer outcomes across all health indicators. Policy interventions aiming to improve population health and economic resilience should integrate health support with efforts to reduce perceived financial insecurity. Addressing both domains simultaneously may help break cycles of disadvantage, particularly among older adults vulnerable to financial and health shocks.

Itinéraire d’un vieillissement en santé (VIeSA) : résultats d’une étude de faisabilité à Genève

BUSNEL, C., ASHIKALI, E. M., VALLET, F., *et al.*

2025

Santé Publique vol. 37(3): 161-177.

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Introduction : La mise en place de projets de proximité répondant à la diversité des besoins des séniors et des ressources locales est l’un des défis du vieillissement en santé. Le projet Vieillissement en santé (VIeSA), réalisé à Genève, a créé un dispositif d’intervention documenté dans un guide regroupant les interventions efficaces, les recommandations issues de la littérature, les prestations santé/social par capacité fonctionnelle, une cartographie locale et des étapes pour accompagner les séniors dans leur détermination d’objectifs de santé et d’actions. Objectif : L’objectif de l’étude est d’évaluer la faisabilité du dispositif dans la mise en œuvre d’un itinéraire de vieillissement en santé basé sur le guide VIeSA. Vingt-neuf séniors et 12 professionnels de la santé ou du social ont testé le dispositif sur une durée de 4 mois. Ils ont évalué la faisabilité, l'acceptabilité, l'utilité, la pertinence des supports, des méthodes, des objectifs personnalisés et des actions mises en œuvre. Résultats : Le dispositif est jugé comme faisable, acceptable, pertinent pour mettre en place des objectifs et des interventions individualisés. Globalement, les résultats sont jugés comme satisfaisants. Les commentaires critiques sur la lourdeur, la trop grande spécificité des supports, en font des apports précieux pour des ajustements à entreprendre. Conclusion : Ces résultats soutenant l'utilisation des outils et méthodes proposés constituent une première étape prometteuse dans l'implémentation d'un dispositif d'accompagnement du vieillissement en santé. Une application à plus large échelle et une évaluation des bénéfices de santé pour les séniors mériteront d'être conduits pour évaluer l'efficacité du dispositif.

« Et si je ne pouvais plus rester seule chez moi ? » : quelles sont les attentes des personnes âgées et de leurs proches concernant les aides et l'accompagnement de la perte d'autonomie ?

CHENEAU, A., SICSIC, J. ET RAPP, T.

2025

Lien social et Politiques(94): 201-238.

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En France, les politiques de l'autonomie vont devoir répondre à une hausse considérable des besoins d'accompagnement de la perte d'autonomie, dans un contexte où l'offre professionnelle de soins est en tension et où le nombre de proches aidants potentiels est amené à diminuer dans le futur. Dans ce contexte, le « virage domiciliaire » a été plaidé récemment, et vise à favoriser le vieillissement à domicile. L'objectif de l'article est d'analyser dans quelle mesure le virage domiciliaire répond aux attentes et préférences des personnes âgées et de leurs proches. Pour analyser les préférences des personnes âgées et des aidants, nous recourons à la méthode d'analyse de contenu, qui permet une analyse inductive des 36 entretiens conduits, à partir d'arbres thématiques. L'analyse de la disposition à se faire aider pour les personnes âgées et de la disposition à aider pour les aidants conduit à questionner la politique du maintien à domicile, dans laquelle on observe un écart entre les attentes respectives des familles et de l'État. Les entretiens montrent que le maintien à domicile repose en grande partie sur l'aide des proches (les enfants et conjoints), qui réalisent la quasi-totalité de l'aide administrative, de la coordination des professionnels, de la surveillance et du soutien à la vie sociale. Une partie de cette aide est « subie », faute d'une prise en charge professionnelle, ce qui peut conduire à des répercussions négatives de l'aide sur l'aidant et à des ruptures de l'aide. Pourtant, les personnes âgées sont unanimes quant à leur volonté de ne pas « trop peser » sur leurs proches, notamment leurs enfants, en cas de perte d'autonomie. Les entretiens mettent également en évidence les représentations négatives des EHPAD (Établissements d'hébergement pour personnes âgées dépendantes) par les personnes âgées et leurs proches, alors même que dans certaines situations (notamment d'isolement ou de forte dépendance avec des troubles cognitifs), l'EHPAD semble plus adapté et bénéfique que le domicile. Aujourd'hui, les ressources financières et familiales déterminent fortement la qualité de l'accompagnement de la perte d'autonomie.

Parcours de vieillissement des aîné·es migrant·es : des réseaux d'aide et d'entraide évolutifs et diversifiés

LAQUERRE, M. E., THÉBERGE-GUYON, M. ET MEZDOUR, A.

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Le vieillissement de la population migrante est un enjeu grandissant au Québec, plus particulièrement à Montréal, où 44 % des personnes âgées de 65 ans et plus sont né·es à l'extérieur du pays. Les recherches montrent que les aîné·es migrant·es sont particulièrement à risque de vivre de l'exclusion sociale en raison de l'existence de barrières culturelles et structurelles reliées à leur contexte migratoire. Plusieurs personnes âgées migrantes disent toutefois bénéficier d'un vieillissement satisfaisant qui semble fortement relié aux formes d'aide reçues et données. À partir d'une étude portant sur le vécu expérientiel des aîné·es migrant·es, cet article met en lumière la spécificité de ces formes d'aide en contexte migratoire tout en soulevant la structuration évolutive des réseaux d'entraide au fil de l'avancée en âge. Des entretiens individuels menés auprès d'aîné·es migrant·es vivant dans la région métropolitaine de Montréal ont permis de faire ressortir les manières plurielles dont ces personnes se situent exclusivement, successivement ou simultanément en position d'aidé·e ou d'aidant·e au sein de leurs réseaux familiaux, amicaux et communautaires. Les résultats mettent en évidence le vécu émotionnel et la dimension affective associés à ces diverses configurations de solidarités, qu'elles soient ou non désirées autrement. La collecte de données s'étant déroulée avant et pendant la pandémie de covid-19, les résultats présentés témoignent des nouvelles formes de soutien qu'elle a fait naître comme de l'effritement de certaines relations d'aide dont bénéficiaient ou auxquelles prenaient part les aîné·es migrant·es vivant au Québec.

Are long-term care systems aligned with person-centered integrated care? Evidence from the Western Pacific

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2025

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BACKGROUND: Many Western Pacific countries have established long-term care (LTC) systems to support their rapidly aging populations. However, the extent to which these systems align with integrated care principles that enable individuals to age in place (AIP) remains unclear. Effective integration of LTC with healthcare is essential to enhance continuity of care, improve outcomes, and support AIP. OBJECTIVE: This study examines the alignment of LTC policies in five Western Pacific countries-Australia, Japan, New Zealand, Republic of Korea, and Singapore-with integrated LTC principles. The analysis identifies systemic enablers and challenges in governance, financing, workforce, service delivery, information, monitoring & evaluation (IM&E), and innovation & research. METHODS: Using an adapted World Health Organization LTC framework, we conducted a comparative analysis of the selected countries' LTC policies. RESULTS: All five countries emphasize aging in place and provide both institutional and community-based LTC services. However, key enablers of integration are often lacking. Fragmentation between LTC and healthcare is common, and coordination mechanisms such as care planning are hindered by inadequate accountability mechanisms due to misaligned incentives, challenges in funding integration, and often underdeveloped information systems for monitoring integrated care. CONCLUSION: Western Pacific LTC systems are not yet fully aligned with effective integrated LTC. Strengthening coordinated and accountable governance, integrating financing streams and incentive, enhancing IM&E systems for performance management, and leveraging innovation are crucial to enhancing integrated LTC in the region.

L'aide au prisme des âges de la vie

MALLON, I. ET MARCHAND, I.

2025

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Ce numéro de Lien social et Politiques propose d'analyser comment l'aide se déploie et se (re)configure au prisme des âges de la vie. À rebours des politiques et des représentations sociales d'une aide segmentée et inégalement convoquée selon les âges de la vie, son intention générale est de documenter et analyser les conditions politiques et les logiques sociales des variations de l'aide aux différents âges de la vie. Il s'agit d'examiner à la fois la production et la réception de l'aide, et les positions ainsi attribuées dans les relations d'aide, qu'elles soient occupées successivement ou simultanément, en lien avec les transformations contemporaines du parcours des âges. Ce numéro s'intéresse ainsi aux conditions sociales et politiques de la visibilisation et de la reconnaissance différenciée de l'aide selon l'âge, dans les activités et les différents modes de relation qu'elle engage, sur les plans politiques, matériels et symboliques et dans divers contextes (institutionnel, communautaire, familial, interpersonnel).

Trajectoire et vécu des aidantes et aidants lors de la crise sanitaire de la covid-19 en France

MEILLAND, C., MELLADO, V. ET TRENTA, A.

2025

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En France, la crise sanitaire du Covid-19 et le confinement généralisé de la population ont exercé une forte tension sur l'activité d'aide des proches de personnes âgées en perte d'autonomie et de personnes en situation de handicap. Les restrictions de déplacement et la fermeture de nombreux services sanitaires et médico-sociaux ont renforcé l'isolement des aidantes et des aidants qui accompagnent leur proche à domicile. Entre mars et mai 2020, une enquête par questionnaire a été menée en ligne auprès des adhérents des associations membres du Collectif Inter-Associatif des Aidants Familiaux (1032 réponses). L'article analyse les différents vécus de l'aide pendant le confinement en comparant les situations selon le genre de l'aidant et le lien avec la personne aidée. Il interroge également la relation entre la trajectoire d'aide et le vécu d'une crise aussi aigüe que la pandémie de Covid-19.

La structuration de l'aide par les positions d'âge dans les politiques départementales de l'autonomie : une remise en cause hésitante

MOALIC-MINNAERT, M.

2025

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En France, les politiques du handicap et les politiques du grand âge constituaient depuis les années 1990 deux champs distincts de l'action publique. En dépit de la création en 2020 de la cinquième branche de la Sécurité sociale, le questionnement de la barrière d'âge au niveau national apparaît largement inachevé. Les politiques de vieillesse ayant fait l'objet, comme les politiques du handicap, d'un processus de décentralisation, il importe de resserrer la focale sur la mise en œuvre à l'échelon départemental d'un service public de l'autonomie unique. Cet article explore l'hypothèse de la constitution par les conseils départementaux d'une nouvelle « catégorie d'action publique » en lieu et place des « personnes âgées dépendantes » et « personnes handicapées ». Afin d'éclairer ce questionnement, une analyse documentaire a été menée. Les organigrammes des conseils départementaux français ont été examinés, tout comme les outils de planification – les schémas autonomie. En complément, une campagne d'entretiens semi-directifs a été initiée auprès des cadres de l'un des conseils départementaux. Bien qu'inaboutie, la convergence, à l'échelon départemental, des politiques du handicap et des politiques du grand âge se donne à voir dans la réorganisation des services, dans les choix d'instruments, à travers le travail cognitif d'identification d'enjeux communs et dans la mise en place de dispositifs communs. La compréhension de chacune des strates de cette convergence nécessite son insertion dans une pluralité de dynamiques à l'œuvre en matière de transformation de l'action publique. La dynamique de rapprochement est en outre différenciée d'un département à l'autre.

Evaluating LTC Policies Around the World: A Virtual Special Issue Promoted by the Gateway to Global Aging Data Project

PASINI, G., KNAPP, D., ANGRISANI, M., *et al.*

2025

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ABSTRACT To promote the evaluation of existing long-term care (LTC) policies and the involvement of the scientific community in future LTC policymaking, the Gateway to Global Aging Data project organized a conference in November 2023. This LTC Policy Virtual Special Issue features eight papers from this conference that were invited to undergo further blind peer review prior to publication in Health Economics. This introduction to the LTC Policy Virtual Special Issue provides a summary of each article, briefly covering the research question, conceptualization of the problem, approach used, methodological challenges, key outcomes and findings, and implications for policy and future research.

How digital and social isolation drive frailty transitions in middle-aged and elderly adults populations: a seven-year multicohort study

QIU, J., CHENG, L., HU, Q., *et al.*

2025

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The rapid expansion of the internet has introduced digital isolation as a new dimension of social isolation, increasingly impacting frailty among the elderly people. We systematically integrated cohort studies from multiple databases spanning up to 7 years across four countries, enrolling 32,973 participants aged 50 years and older who reported social and digital isolation status at baseline and underwent at least two frailty assessments which used The Frailty Index (FI) to evaluate. Using multi-state transition models to analyze bidirectional frailty transitions and Generalized Estimating Equations (GEE) for average FI effects, we found that social isolation bidirectionally influenced transitions: it increased deterioration risk (robust→pre-frail: HR = 1.11, 95 %CI 1.06–1.15; pre-frail→frail: HR = 1.16, 1.11–1.22; frail→death: HR = 1.29, 1.20–1.40) and reduced recovery likelihood (pre-frail→robust: HR = 0.92, 0.87–0.98; frail→pre-frail: HR = 0.87, 0.81–0.94), with intensifying effects in poorer health states. In contrast, digital isolation primarily accelerated frailty progression, especially in healthier and younger-old adults (robust→pre-frail: HR = 1.50, 1.42–1.59; pre-frail→frail: HR = 1.23, 1.16–1.30; frail→death: HR = 1.38, 1.26–1.52). Concurrent digital and social isolation significantly elevated mortality risk. These results demonstrate different characteristics by which two types of isolation impact transitions necessitating targeted, health-status-specific interventions supported by family-community collaboration to mitigate risks.

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