Integration of behavioural insights into a general theory of health economic policy

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Abstract. The study aimed to conceptualise the role of behavioural economics mechanisms as a component of the modern theory of economic policy in the healthcare sector. The paper used the methods of modelling the cause-and-effect chain "tool – mechanism – behaviour – change – clinical outcomes – economic effect", content analysis of international research materials, abstraction of the system of indicators (behavioural, clinical, economic), systematic analysis of performance indicators (Incremental Cost-Effectiveness Ratio and return on investment, budgetary impact analysis). The findings demonstrated that structured reminders, scheduling prompts, social norms, and comparative feedback to providers reduced delayed visits, increased adherence, and reduced unnecessary procedures, which translated into lower intensity of costly episodes of care, more consistent quality of care, and reduced indirect productivity losses. The macroeconomic and fiscal implications of integrating behavioural insights into the general theory of economic policy were identified, including improved public health, which affected life expectancy and morbidity. Also, it was increased attendance and productivity, impact on the macroeconomy, which meant higher output, employment growth, as well as increased tax revenues, and lower disability benefits. A roadmap for implementation was proposed, which combined ethical principles of using behavioural tools, requirements for data infrastructure and mechanisms for regular monitoring ("planning – collection – analysis – feedback – correction"), allocating funding on results (key performance indicators: prevention coverage, proportion of healthy population, frequency of over-prescribing). The practical value was determined by an economically sound basis for reallocating resources towards preventive healthcare, increasing cost-effectiveness of expenditures and strengthening long-term fiscal sustainability through the channels of attendance, productivity and employment

Keywords: healthcare financing; default options; social norms; message framing; assessment indicator system; budgetary impact; public policy

Introduction

The integration of behavioural economics insights into the general theory of health economic policy determined the ability to redirect financial flows from volume-dependent procedures to measurable outcomes and increase the cost-effectiveness of expenditures. With significant institutional capacity, the national healthcare system faced the challenges of uncoordinated incentives for providers, insufficient preventive care, and fragmented routes to care. Therefore, the development and implementation of coherent approaches to embedding behavioural mechanisms into the economic cycle was crucial to both reduce costs and productivity losses, and to strengthen and improve the competitiveness of the system.

In Ukraine, there was a gap between the declared outcomes-based orientation of healthcare policy and the actual logic of the instruments, where volume-dependent incentives and fragmented initiatives dominated,

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and behavioural factors of patient and physician choice remained outside the core of regulatory decisions. At the same time, performance measurement focused on process indicators and initial costs, while indicators of intention, adherence, sensitivity to default options and protocol adherence were not integrated into a single monitoring model. The uncertainty of Key Performance Indicators (KPIs) for providers, including the lack of an explicit focus on the proportion of the population that was healthy, hinders the transition to a preventive model and made it impossible to verify the long-term effects of government programmes on employment, productivity and fiscal sustainability. D.D. Reed *et al.* (2022) conducted a systematic review of the transition of behavioural economics ideas from laboratory experiments to public health policy tools. The focus was on the guided choice design within the full policy cycle. The study demonstrated that defaults, the way messages were formulated, and planning cues had a sustainable effect only, when integrated with barrier diagnosis, piloting, measurement, and subsequent correction. Instead, the study by O. Kovtun *et al.* (2024) proposed to estimate the size of key and transitional groups using the network extrapolation method, which was relevant for behavioural risk infections. In the context of integrated economic policy, this meant that behavioural insights became quantitative benchmarks for resource allocation. Accordingly, the performance measurement system should include not only outcome indicators, but also intermediate markers of behavioural change in targeted networks to link financial decisions to real channels of influence on morbidity and costs.

In the context of the national healthcare system, K. Dorykevych & Y. Kremin (2022) analysed the attitudes of Ukrainian citizens towards vaccination, revealing a range of factors that shaped the intention to get vaccinated, from trust in medical institutions to the influence of the immediate environment. This gave grounds for including behavioural indicators, including intention, expectations, and risk perception, in the economic policy evaluation system. At the same time, the study by V. Fardhdiani *et al.* (2025) demonstrated that the combination of innovative models with systemic adherence support can ensure sustainable recovery trajectories even in a difficult environment. The study found a practical link between simple adherence support tools, reduction of barriers to care, and clinical and economic outcomes. A. Atif (Nurzhynska) *et al*. (2024) compared several communication approaches to increasing vaccination adherence (social and normative messages, loss-oriented formulation of non-vaccination risks) and showed that the result was determined not only by the content, but also by the form of presentation and source of the message. Experts had shown that communication architecture was a component of economic policy, along with prevention financing and service organisation. According to the experts, effectiveness evaluation should not only record vaccination coverage, but also intermediate behavioural indicators of intention and attitude change.

At the same time, the study by K. Hook *et al.* (2021), using the example of healthcare professionals in Kyiv, revealed the perception of training in evidence-based approaches in psychiatry, as well as the limiting factors that prevented clinical behaviour change. The analysis made it possible to evaluate behavioural decisions at the provider level: checklists, simple clinical prompts at the time of decision-making, and comparative feedback. Researchers P. Yeboah *et al.* (2025) focused on the main vaccination hesitations among young people. The authors demonstrated that vaccination decisions were shaped by a combination of trust in sources, risk perception, sense of collective responsibility, and accessibility of the service. The findings highlighted the need to combine organisational and financial decisions with behavioural components of communication, where the form and medium of the message were as relevant as its content. I. Pinchuk *et al*. (2025) highlighted the role of predictable channels of access and continuity of care. The analysis of psychiatric care during the war revealed a persistent need for services amidst prolonged stress and disrupted life trajectories. The findings set the benchmarks for the indicator system: the assessment should cover not only the volume of visits and costs, but also the parameters of the choice architecture, continuity of care and their economic consequences.

Existing research on the integration of behavioural approaches into health economic policy was dominated by a focus on individual tools and local pilots, while a holistic model that combined behavioural indicators of intention, adherence and compliance with clinical and budgetary indicators in a single policy evaluation cycle remained underdeveloped. Issues related to the integration of administrative data sources to build robust metrics, evaluate the effectiveness of financing designs, and assess insurance defaults were not fully addressed in research. The study aimed to substantiate the conceptual foundations of behavioural economics in the general theory of healthcare economic policy. To achieve this goal, a set of tasks had been identified: to develop a conceptual model of the causal chain "tool – mechanism – behaviour – change – clinical outcomes – economic effect"; to form a system of indicators for policy evaluation that combined behavioural, clinical and budgetary indicators; to assess the potential macroeconomic and fiscal impact of behavioural programmes.

Materials and Methods

The study used a descriptive approach to systematise modern practices of integrating behavioural insights into healthcare economic policy in the context of constant institutional and technological change. The analysis was based on theoretical models of behaviour change management and policy design used in international practice. The empirical materials used in the study

include data from the Organisation for Economic Co-operation and Development (2022) and International Bank for Reconstruction and Development/The World Bank & World Health Organization (2024). In particular, the paper considered frameworks that provided a systematic assessment of the "mechanisms of action" of interventions and their alignment with health outcomes and costs, including the behaviour change wheel approach, nudge tools, and the principles of phased policy development. These models were selected for their focus on strategic planning, alignment with evidence-based requirements, and suitability for integration into the digital health environment. The features of soft interventions based on a research case study of a randomised cluster clinical trial in the United States were explored (Bachhuber *et al.*, 2021). A descriptive method was used to assess the economic effect of implementing behavioural interventions. The essence of the cost – effectiveness and cost-benefit analysis methods were defined, and the role of the Incremental Cost-Effectiveness Ratio (ICER) was clarified (Lytvynenko *et al.*, 2018). Formula 1 was investigated:

$$ICER = \frac{(DC_1 + IC_1) - (DC_2 + IC_2)}{E_{f1} - E_{f2}}, \qquad (1)$$

where $DC_1 + IC_1$, $DC_2 + IC_2$ – direct and indirect costs, when using the first and the second solutions, respectively; E_{f1} and E_{f2} – the quantitative treatment effectiveness indicators, when using the first and second solutions, respectively.

The essence of the concept of ROI (Return on Investment) was defined, which reflected, how much additional income or savings were generated for each invested monetary unit (Yurchyk, 2024):

$$ROI = \frac{Net\ profit}{Investments} \times 100\%. \qquad (2)$$

Examples of the use of soft healthcare interventions were studied based on the case of England, on the example of modelling colorectal cancer screening using the cost-effectiveness model (Murphy *et al.*, 2017) and the case of Spain on the example of preoperative smoking cessation programmes using the cost-benefit model (Jiménez-Ruiz *et al.*, 2020). Based on the research of S. Michie *et al.* (2014), National Institute for Health and Care Excellence (2022), and International Bank for Reconstruction and Development/The World Bank & World Health Organization (2024), a "map of correspondences" of the causal chain "tool – mechanism – indicator – expected effect" was built. A structural and functional analysis of different groups of interventions and operational tools for their implementation at different levels of the system was conducted. In particular, the study addressed standard preventive care appointments, reminders with specific actions, personal commitment tools and game-based motivation elements at the patient level; checklists, clinical prompts at the point of decision, comparative feedback and prescription appropriateness protocols at the provider level; transparency of routes and prices, standardisation of insurance options and simplification of transaction barriers at the system level. These mechanisms were chosen due to their scalability, low specific cost of implementation, ability to target vulnerable groups, and compatibility with existing data infrastructure.

Cases were also analysed on increasing vaccination and screening coverage through standardised records and patient navigation; reducing unnecessary prescriptions through checklists and comparative feedback; and improving adherence to treatment through scheduling prompts and multi-channel reminders, illustrating the "tool – mechanism – behaviour – outcome correlation". This approach characterised the criteria for selecting tools based on context (age, socioeconomic and cultural characteristics, level of digital accessibility) and built a "map of relevance" that combined behavioural, clinical and economic indicators. Based on this, practical recommendations were developed on the sequence of implementation: from behavioural diagnostics and pilot projects to scaling up with constant monitoring and correction based on the results.

Results

Theoretical and methodological foundations for the integration of behavioural approaches

Everyday decisions of patients and healthcare providers were made under conditions of asymmetry of information and limited cognitive resources, which led to distortions in risk perception, dominance of urgent actions over prevention, and excessive focus on the volume of procedures. Behavioural economics as a scientific field offered a model for analysing such distortions through the concepts of bounded rationality, heuristic approaches and the influence of the context of choice, providing opportunities for constructive complementation of healthcare economic policy. The key behavioural mechanisms that can be integrated into economic policy, their methodological foundations and theoretical premises served as the basis for a model of performance measurement using indicators that reflected behaviour, clinical outcomes and economic impact (Saposnik, 2019).

Decisions by healthcare actors were shaped by cognitive, time and financial constraints, which led to deviations from the assumptions of classical rationality. Patients often tended to prioritise immediate benefits and postpone decisions related to long-term health, which results in underestimation of preventive measures and delayed care seeking (Patel *et al.*, 2018). At the same time, the way information was presented has a significant impact on behaviour: clear wording, properly configured default choices, and timely reminders increase the willingness to follow medical recommendations and reduce the risk of undesirable deviations from treatment protocols. For providers (healthcare

professionals), decisions were also shaped by limited attention, time, and protocol complexity, which increased the likelihood of diagnostic and procedural errors and variability in practice (Hoenink *et al.*, 2020). Behaviour was also strongly influenced by professional guidelines and peer examples: clear clinical reminders at decision-making points, standardised checklists, and comparative feedback increase adherence to protocols and reduce overprescribing (Saposnik, 2019). Combined with transparent criteria for evaluating the results of protocol adherence, treatment adherence, and avoidance of duplication of procedures, such tools contribute to a more consistent quality of care and more efficient use of resources.

Notably, these factors led to a situation, where choices often reflected neither real preferences nor socially optimal outcomes. Patients, guided by short-term benefits, postpone preventive measures, neglect screening, and discontinue treatment after symptoms disappear, which, in the long term, increased the financial burden on the system and productivity losses. Providers, due to cognitive simplifications and peer influence, often deviate from protocol standards, prescribing excessive or duplicative procedures, thereby increasing transactional and medical costs. Health economics research shown that incorporating behavioural mechanisms such as default options, clear messages, reminders and comparative feedback can change decision-making trajectories, reduced error rates and created incentives to adhere to treatment protocols (Thaler & Sunstein, 2021; Organisation for Economic Co-operation and Development, 2022). Therefore, bounded rationality was not just a descriptive characteristic, as it defined the practical scope for integrating behavioural tools into the design of health economic policy aimed to reduce irrational costs and increase the effectiveness of public programmes.

The essence of bounded rationality determined both individual patient behaviour and professional practices of providers, creating the basis for systemic deviations from economically and clinically optimal solutions. At this stage, it became necessary to analyse the specific mechanisms, by which healthcare decisions were formed and adjusted. Default options, framing effects, and social norms all form the core of behavioural tools that provided a realistic explanation for deviations from classical rationality and can be used for targeted use in policy making (International Bank for Reconstruction..., 2024). One mechanism to adjust the behaviour of healthcare actors was default options, which, through choice design, can significantly alter patient or provider choices without directly changing financial incentives or regulations. For example, research on the behavioural dynamics of physicians has shown that changing default settings and providing social references consistently increase professional compliance with treatment standards (Hoenink *et al.*, 2020). The way messages were presented, and the accessibility of information had a

significant impact on risk attitudes and willingness to take preventive action. Well-designed messages help to reduce common risk factors, such as tobacco use, physical inactivity, and unhealthy diets.

Social norms were an effective tool for changing the clinical behaviour of healthcare professionals. Interventions with comparative feedback on peer practices and support from an authoritative source consistently increased adherence to protocols and reduced prescribing variability (Patel *et al.*, 2018). It was possible to add that social comparison became more effective, when accompanied by cues and rewards, which created external reinforcement for the transition from intention to action. The analysis of such mechanisms shown that, when scaling up their use, it was necessary to consider the context of the type of healthcare service, provider type, and communication channel, as the effect depends on how much the reference group is perceived as authoritative, as well as the relationship between the message and the usual decision-making environment.

Loss aversion, another key mechanism of behavioural economics, was that people seek to avoid losses to a greater extent than to gain similar benefits. In the International Bank for Reconstruction and Development/ The World Bank & World Health Organization (2024) data on health behaviour change, this mechanism was manifested in messages that emphasised the possible costs of poorer health, increased costs, or the risk of complications if preventive measures were not taken. Such language can encourage a faster response to recommendations and accelerate the uptake of screenings and vaccinations, especially among high-risk groups. In practical terms, this meant that health economic policy can be much more effective if its instruments included not only positive incentives and information, but also the triggering of fear of loss, with mandatory compliance with ethical standards and transparency. The framing of messages determined, how people perceive the likelihood of risk and benefit: the same information can lead to different decisions depending on whether it was presented in terms of potential losses or gains. In the health sector, this was evident in the fact that messages that emphasised the risks of not vaccinating or not adhering to therapy, for example, stimulate a higher willingness to act than neutral or exclusively positive language (Organisation for Economic Co-operation and Development, 2022). In addition, planning prompts created a clear link between intention and actual behaviour. Patients, who formulated a specific plan of action ("when and where to get tested") were much more likely to follow their doctor's recommendations. Taken together, these mechanisms demonstrated that integrating behavioural tools into health policy design can reduce delayed prevention, increase treatment adherence, and create indicators that reflected not only the outcome, but also the process of behaviour change (International Bank for Reconstruction..., 2024).

These mechanisms demonstrated that even minor changes in the way information was presented, or the structure of choices can influence the behaviour of patients and providers. This meant that the healthcare system responded not only to financial incentives or administrative regulations, but also to the specifics of the decision architecture, which determined, which options will be chosen more often, faster and more consistently. A policy based on choice design principles combined price incentives and soft interventions to improve healthcare efficiency without significantly increasing the budgetary burden. For example, a U.S. healthcare network conducted a randomised cluster clinical trial in which standard electronic prescription templates for outpatient procedures reduced the "default" value for the amount of opioid-based painkillers (Bachhuber *et al.*, 2021). While medical staff were still free to change this amount, the initial setting shifted the "inertial" decision to a safer limit: the average number of pills dispensed decreased significantly without any signs of worsening pain control or increased repeat visits. This was a good example of a "soft" intervention: it was not prohibited or penalise, but adjusted the context of choice so that the typical scenario became more cautious and cost-effective. A similar approach had been replicated in other emergency departments, with similar results of lower opioid prescribing without adverse patient outcomes. Taken together, these findings suggested that setting "defaults" in routine processes can be a low-cost tool for improving the quality and safety of care.

The U.S. case study identified the boundaries that behavioural interventions can push: the need for ethics commissions, data protection regulations, and rules on information manipulation; the absence or weak regulation in these areas increased the risk of abuse and undermines trust. Thus, the integration of behavioural instruments into economic policy should be based on the legal environment, ethical standards, and public perception to ensure a balance between efficiency and safeguards for system actors. The use of behavioural insights in public health policy was not without ethical issues: changing choices through default settings or message framing can limit patient autonomy if information and the ability to refuse were not ensured (Organisation for Economic Co-operation and Development, 2022). It should be emphasised that all stages, from diagnosing the problem to scaling up interventions, should be transparent and comply with the principles of fairness, privacy and accountability. It was possible to conclude that the classical rational choice model was not explain the actual practices of patients and providers: cognitive limitations, information asymmetry, and time barriers led to avoidance of optimal decisions. This created room for the use of behavioural tools that can reduce transaction and medical costs, increase treatment adherence, and improve preventive behaviour. Key mechanisms, including default options,

framing effects, social norms, and loss aversion, determined the sensitivity of subjects to the choice architecture and form the basis for behavioural interventions in healthcare. The combination of price incentives and soft nudges provided a more sustainable effect than using each approach separately. At the same time, behavioural tools can affect autonomy of choice, so their use should be based on the principles of transparency, voluntariness and data protection.

Conceptual model and system of performance evaluation indicators

Building a health policy that was strengthened by behavioural approaches required not only a description of the tools, but also a clear logic for measuring them: how a management decision changed the behaviour of patients and providers, through what mechanisms it translated into clinical outcomes, and what the final economic impact was (International Bank for Reconstruction…, 2024). Therefore, there was a need to formalise the causal chain and develop a coherent system of indicators that covered behavioural changes, operational and clinical indicators of quality of care, and economic metrics of costs and productivity. Such an approach can be used not only to state the existence of an effect, but also to identify the channel of its occurrence and ensure policy adjustments based on valid, attributable and change-sensitive data.

Behavioural indicators captured the "drivers" of policy effects, those changes in decision-making and implementation that immediately preceded clinical outcomes. The basic distinction was between typical intention, which reflected the willingness to take an action (to be screened, to start therapy), and implementation, which was responsible for specifying, when, where and how it will be done. In practice, this measurement was combined with indicators of adherence to treatment (regularity of appointments, timely refills of prescriptions, completion of the course) and response to default options and reminders: the proportion of those automatically enrolled, who did not opt out; the proportion of those, who responded to the message within a specified time window; the speed of transition from intention to action (International Bank for Reconstruction…, 2024). Sensitivity to social norms was monitored through indicators that compared the behaviour of an individual with a reference group (deviation from the median practice in the department, level of compliance with protocols in the team), as well as through changes after providing comparative feedback. Such indicators should be recorded in short intervals, stratified by age, gender and socioeconomic characteristics, and accompanied by a baseline to attribute the impact of the policy instrument, considering external factors.

The behavioural block was logically completed into clinical and operational indicators, as changes in intentions and implementation determined coverage of

preventive services, timeliness of referrals, and sustainability of treatment (International Bank for Reconstruction..., 2024). At this level, the key indicators were coverage (proportion of the target group that has undergone screening or preventive examination within the recommended interval), hospitalisations and their structure (neglected complications, emergencies, planned episodes), readmissions (repeat hospitalisations or relapse within a specified time window), delayed visits (overdue screenings or missed visits as an indicator of access barriers), and sustainability of the effect (maintenance of improvements over several follow-up cycles without additional reinforcement). Operational metrics, such as time to service, episode duration, and workload at the point of care, can be used to assess whether behavioural changes were translating into predictable clinical trajectories and whether policy instruments were creating undesirable "spillovers" of demand between types of care. Alignment of behavioural and clinical measures increased the validity of causal inferences. For example, an increase in the proportion of screening intentions that were realised should be associated with a decrease in late readmissions and re-admissions.

Instead, economic indicators translated the effects of these changes into costs and welfare. To determine the incremental economic costs of achieving more clinical outcomes, a cost-effectiveness analysis was used. This approach compared both the cost and effectiveness of alternatives in the same units of outcome to determine, which solution delivered a given effect at a lower cost, and the main goal was to calculate the unit cost of the effect and the additional amount needed to obtain the increase in the result (Lytvynenko *et al.*, 2018). The requirements for the correct application of the method included a clear choice of outcome indicators, identification and monetary valuation of costs, as well as adjustments for time and uncertainty, which ensured comparability of alternatives and validity of conclusions for policy. The solution that was found to be more effective than the other options was identified as the dominant solution. If no solution was identified as dominant, an incremental analysis was carried out, in which the ICER was calculated. The ICER value (Formula 1) shown the cost of an additional unit of effectiveness, when switching to a more effective solution (treatment).

An example was the case of England, where the best way to organise colorectal cancer screening in a national programme was evaluated (Murphy *et al.*, 2017). The researchers compared old occult blood tests with a new immunochemical test, modelling different thresholds and health and cost implications. As a result, they built a model of the course of the disease and screening for a large group of patients and calculated, how many additional years of life, incorporating the quality of life, the new approach brings, and what the additional cost was of each unit of such effect. The study noted that the immunochemical test was superior to the previous one: at

any threshold, it provided more health benefits, but at the same time reduced the total costs of the system, although it required more colonoscopies at lower thresholds. This was an example of the cost-benefit analysis model in action: a management decision was evaluated by the health outcome and by the unit cost of achieving it, which can be used to choose a programme configuration that delivered more health for every UAH invested.

Once a decision has been made, the question of whether it was feasible to implement it arises. For this purpose, a cost-benefit analysis was applied, which compared the expected economic return from the implemented solution with the costs of its launch and support within a given budget. The assessment was based on an agreed set of indicators that can be used for ranking alternatives and justifying the allocation of resources, among which the basic indicator was ROI (Formula 2), which reflected how much additional income or savings were generated for each invested monetary unit (Yurchyk, 2024). At the same time, higher values indicated a greater attractiveness of implementation. This combination of metrics not only provided a statement of the effect, but also formed a transparent criterion for choosing between competing solutions. An illustrative example of the use of cost-benefit analysis in clinical policy was the case of Spain, where the feasibility of funding smoking cessation programmes for patients before elective surgery was assessed (Jiménez-Ruiz *et al.*, 2020). The intervention combined medical counselling and prescription of smoking cessation products in advance of hospitalisation. The benefits were calculated as the costs avoided due to fewer postoperative complications in those, who stopped smoking. Comparing the full costs of implementation with the monetised benefits showed a positive balance and a significant economic return for the public health system: the programme increased the proportion of smokers, who quit, while reducing the costs associated with complications, i.e. the "benefits" outweigh the "costs". The result can be used to rank the alternatives (to leave things as they were or to fund smoking cessation support) and justified the allocation of resources in favour of pre-surgical prevention, as it reduced clinical risks and budget burden simultaneously.

The budgetary impact shown, how expenditures change in the short and medium horizons under the implementation scenarios, including the redistribution between outpatient and inpatient care. Unproductive days and lost productivity were also considered as indicators of macroeconomic impact, as reduced sickness absence and premature disability were expected consequences of increased prevention coverage, timely treatment and sustained adherence. The combined consideration of ICER, ROI, budgetary impact, and lost productivity provided a complete evaluation cycle from behaviour change to long-term fiscal and economic feasibility. In the context of the analysis, it was advisable

to model a conceptual framework, within which the system of performance evaluation indicators clearly reflected the logic of the transition from a management decision to a measurable impact. A causal chain of "tool – mechanism – behaviour – change – clinical outcomes – economic impact" can be formed, which comprehensively described the sequential comparison of management interventions with behavioural changes, their clinical continuation and the final economic impact, which created a basis for valid monitoring and timely policy adjustment.

The starting point was a policy instrument (e.g., a default appointment for a preventive checkup or modification of reimbursement rules) that activated a specific mechanism of action to simplify choices, reduced barriers to access, changed expectations, or strengthened social norms. The mechanism of action was materialised in a shift in decision-making processes to reduce barriers, increase the visibility of useful options, change expectations, or align professional practice norms (National Institute for…, 2022). It was at the level of the mechanism that short-term behavioural indicators were determined: the proportion of people, who have kept a default record, the timeliness of the first visit, adherence to appointments, and compliance with protocols. These indicators should be recorded with high frequency, be comparable to the baseline, and stratified by key characteristics to ensure that the effect of the instrument was attributed to the instrument, rather than to random fluctuations or external shocks.

At the same time, behavioural changes were translated into clinical outcomes through predictable trajectories: increased preventive care coverage, reduced late visits, stabilised adherence to treatment, and reduced prescription variability. At this stage, indicators of the average hospitalisation horizon and their structure, repeat cases in a fixed observation window, timeliness and continuity of care, and sustainability of the achieved effect without additional reinforcement were considered (Michie *et al.*, 2014). Consistency of dynamics between behavioural and clinical metrics increases the validity of causal conclusions and can localise problem areas in the chain. These clinical outcomes were then translated into economic benefits through reduced direct costs per episode of care, avoided complications, and reduced indirect productivity losses. For a complete picture, complementary metrics were used: marginal cost-effectiveness to compare alternative approaches in a common target population, discounted return on investment to assess the attractiveness of the programme to payers, budgetary impact analysis for short- and medium-term costs, and measurement of sick days and lost productivity as a macroeconomic extension of clinical improvements (Michie *et al.*, 2014). The combination of these metrics completes the cycle from tool design to fiscal sustainability. Table 1 offered a "map of correspondences": how a particular policy instrument (what is it?) triggers a mechanism of action (how?) that produced measurable shifts in behaviour, clinical outcomes, and ultimately economic impact.

Table 1. *"Correspondence map" of the causal chain "tool – mechanism – indicator – expected effect"*

Policy tool	The main mechanism of action	Behavioural indicators	Clinical indicators	Economic metrics
Default appointment for preventive screening	The tool simplifies the choice and reduces transaction barriers, as the patient already has a record and only confirms or refuses	The proportion of people, who saved a pre-existing appointment, the timeliness of attendance at screening, and the average time between invitation and visit are tracked	Increased screening coverage in target groups, reduced proportion of late-stage detection and reduced emergency hospital admissions related to advanced cases	Reduced complication costs, improved cost-effectiveness compared to modern practices, and positive payback for the payer are assessed
Reminders with a specific action plan (emails)	The tool increases the visibility of the task and helps to move from intention to execution by recording the time, place and method of action	Measures the proportion of people, who responded to messages, the proportion of completed prevention or treatment episodes, and the punctuality of visits	There is an increase in completion of therapy courses, a decrease in missed visits and more uniform follow-up schedules	Reduced readmissions and unproductive days by major nosologies, as well as a neutral or positive impact on the budget in the short term
Comparative feedback for doctors	The tool activates social norms by establishing reference points and reducing the variability of practices in teams	The proportion of prescriptions that comply with the protocols and the deviation of individual indicators from the median of the department or facility are assessed	Reduced redundant and duplicate procedures, lower complication rates and more uniform compliance with treatment standards	Measures the reduction of direct costs per episode of treatment, improvement of cost-effectiveness indicators and cost savings in inpatient care
Checklists and clinical prompts at the point of decision	The tool reduces cognitive load and increases the accuracy of decisions at the moment of contact with the patient	It tracks the proportion of prompts used, the proportion of correct assignments, and the average decision time	There has been an increase in protocol compliance, a decrease in procedural errors and repetition of diagnostic procedures	Reduction of costs associated with errors and formation of a positive payback of the implementation in the near-term horizon are estimated

Table 1, Continued

Policy tool	The main mechanism of action	Behavioural indicators	Clinical indicators	Economic metrics
Modification of reimbursement with reference to the result (performance KPIs)	The tool aligns provider incentives with health outcomes, shifting the focus from volume to performance	Measures the proportion of patients with a completed clinical cycle, adherence to treatment and timeliness of referrals within the route	Reduced complications, reduced readmissions and increased coverage of preventive services	Analyses the gradual reduction of complication costs, positive budgetary shift and increased payback of programmes in the medium term
Transparency of routes and prices (patient navigators)	The tool reduces information asymmetry and simplifies the route to care, reducing navigation errors	The time from the onset of symptoms to the first visit, the proportion of correct referrals on the first attempt and the number of disrupted appointments are assessed	There is a decrease in late applications, a reduction in unnecessary consultations and an increase in the timeliness of service provision	Reduced patient routing costs, stabilised budget figures and reduced unproductive days
Standardisation of insurance options	The tool reshapes the architecture of coverage plan selection by encouraging preventive packages and predictable out-of-pocket costs	Measures the share of plans with enhanced preventive coverage and the frequency of plan changes during the year	There is an increase in the use of preventive services and a reduction in access barriers for vulnerable groups	Analyses the reduction of long-term costs, improvement of the total cost efficiency of the portfolio and a positive budgetary effect in the medium term
Simplification of the therapy route (co-location of services, "one-stop clinics")	The tool reduces transaction costs and losses at the route stages by combining the necessary procedures in one visit	The proportion of patients, who complete a full episode in one visit and the proportion of losses at intermediate stages of the route are tracked	There is an increase in continuity of care, a decrease in deferred visits and a reduction in repeat episodes	The reduction of total costs per episode and the reduction of unproductive days are determined, which forms a positive payback of the implementation

Source: *based on S. Michie et al. (2014), National Institute for Health and Care Excellence (2022), International Bank for Reconstruction and Development/The World Bank & World Health Organization (2024)*

The Table 1 served as a matrix of responsibilities between chain elements and monitoring metrics. For each tool, the leading mechanism of action (e.g., acceptance of default options; increased visibility of a healthy alternative; route standardisation), behavioural indicator, relevant clinical outcome and expected economic impact were indicated. The integration of indicators into the policy evaluation cycle was built as a continuous process of "planning – collection – analysis – feedback – correction". At the planning stage, the target behaviour was defined, the tool was selected, and its mechanism of action was described; a set of indicators for each link was formed, and baselines and success criteria were established. At the data collection stage, regular data was extracted from primary sources at a specified frequency and with quality control, including protocols for identifier matching and privacy protection. The analytical stage involved checking the internal logic of the chain: whether the behaviour change was consistent with the expected mechanism, whether there was a consistent transition to clinical and economic changes; stratification was used, and the sensitivity and robustness of the results were checked. Feedback was provided to policymakers, payers, and providers in a format that identified problem areas along the chain (e.g., high levels of intent without implementation or improvements in process metrics without changes in clinical outcomes). The correction stage involved point changes to the tool: clarifying messages and communication channels, reconfiguring defaults, modifying reimbursement or routing rules, and then repeating the cycle with an updated baseline. Such an organisation ensured causal transparency between the instrument and the consequences and can be used for the timely transfer of resources to the most effective policy components.

Behavioural policy instruments and levels of influence
The deployment of behavioural approaches to health economic policy should be structured around three levels of influence: patient, provider, and system, with constant adaptation to the context (European Vaccination..., n.d.). This approach can be used for linking specific tools to mechanisms of action (simplifying choices, reducing barriers, relying on social norms) and tracking the pathway from behaviour change to clinical and economic outcomes. Coherence with policy planning, monitoring and adjustment cycles was ensured by including behavioural indicators in the evaluation system alongside clinical and cost indicators.

At the patient level, the basic element was automatically generated ("default") appointments for preventive services, reminder systems and methods that can encourage people to commit to action (Levesque *et al.*, 2013). Automatic pre-registration with the right to refuse increased the acceptance of preventive interventions, as it reduced the time spent on searching and planning. The effects of such "default options" for

vaccinations and screenings have been confirmed in several local studies. Simple reminders (messages, phone or mail) significantly increased attendance and adherence to treatment regimens, and effectiveness increases with clear "when and where to act" (Gidengil *et al.*, 2016). Communication interventions should be based on clear, culturally appropriate messages and transparent sources of trust. It should also be added that these interventions can be combined with moderate game mechanics and social incentives (goals, feedback, "teams"), if necessary, which have been shown to increase physical activity and adherence to routine activities in controlled trials.

At the provider level, standardised checklists, clinical prompts at the point of decision and comparative feedback were substantial. Implementation of validated checklists has been associated with reduced complications and mortality in surgery, while regular anonymised ratings indicating "best practice" reduce unnecessary prescribing (e.g., the behavioural intervention antibiotic stewardship in primary care, which was used to influence clinical decisions by physicians) (Ely & Graber, 2015). To reduce diagnostic and procedural errors, simple "hardwired" defaults in electronic systems (basic dose or pathway settings) that preserved physician autonomy, but push for protocol decisions were effective. Aligning these tools with performance metrics shifted the focus from "procedure volumes" to quality and safety. At the system level, reducing transaction barriers and streamlining choices was fundamental (Bao & Bardhan, 2024). Increasing transparency of routes, simplifying insurance options, and standardising basic packages reduced choice overload and improves plan fit. The experience of insurance plan choice programmes shown that without guidance and standards, people systematically overpay and underestimate long-term costs, and a combination of information, smart defaults, and limiting plan complexity improved the quality of choice. Additionally, measurable access (geographic, financial, organisational eligibility) should build on recognised affordability and universal coverage frameworks to adjust policies not only for clinical, but also for social outcomes.

It should be noted that adaptation to the context was a necessary condition for scalability. Segmentation of target groups (by age, gender, socioeconomic status), digital accessibility and cultural relevance of messages increase the sensitivity to interventions without increasing the budget. Elements of social marketing in the health sector, such as audience research, value exchange, and message testing, were used in everyday practice by international organisations for systematic planning of prevention campaigns and are compatible with behavioural nudges (Ely & Graber, 2015). At the level of procurement and financing, it is beneficial to combine soft instruments with price signals (subsidies/franchises), as the combination of price changes and nudges often has a stronger and more uniform effect across different social groups than either approach alone. Enshrining a preventive focus required accountability metrics that reflected the health status of the population, not just the volume of services (Bao & Bardhan, 2024). The practice of organisations with shared accountability for results shown that combining quality and cost indicators (in the spirit of the "triple bottom line": population outcomes, patient experience, per capita costs) aligned the incentives of providers and planners and focused resources on preventing complications and avoiding hospital admissions.

Macroeconomic and fiscal implications: Implementation roadmap

The mechanism of improving the health of the population works as a productive asset of the economy: fewer absences from work, higher rates of working hours and labour efficiency, and more stable employment. In terms of economic impact, this generated added value and a tax base. A European review had shown that poor health undermined economic growth through reduced labour market participation and longer periods of disability, while investments in prevention and early detection reduced these losses and support national gross domestic product (GDP) and employment (Thaler & Sunstein, 2021). Figure 1 shown the economic impact of improving the healthcare system.
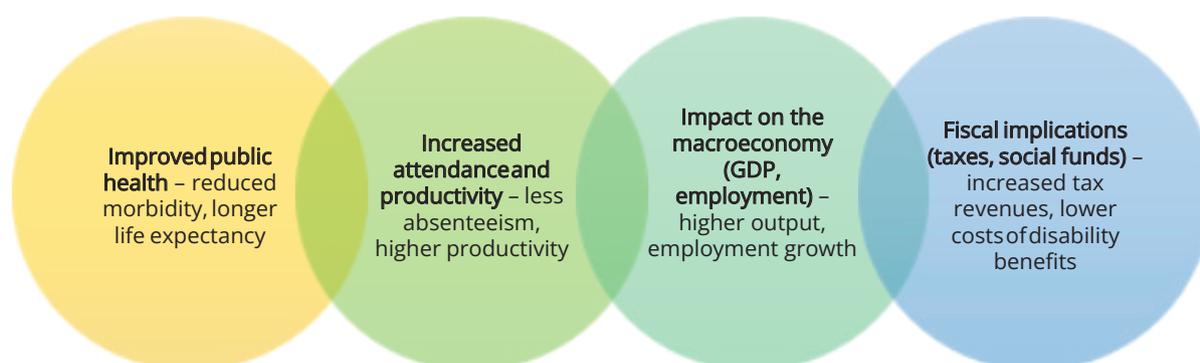

Figure 1. *Economic effects of population health improvement*
Source: *developed by the author*

The budgetary implications of integrating behavioural tools have a two-level dynamic. In the short term, the national healthcare system needs to implement modernised solutions, including digital analytics, IT tools, communication, and training, while in the medium and long term, financial pressure was reduced due to avoided complications, hospitalisations, and readmissions, as well as a redistribution of demand from expensive inpatient episodes to outpatient prevention (Organisation for Economic Co-operation and Development, 2022). This approach correlated with the international health technology assessment framework, which required the analysis of budgetary impact alongside cost-effectiveness. To formalise the choice between a basic (standard) and a "behaviourally enhanced" design, a generalised public benefit function was used, where the welfare gains can be estimated as the difference between the economic effects on health values combined with the fiscal and incremental costs of implementation (International Bank for Reconstruction…, 2024). At the toolkit level, this was specified through standard metrics: the incremental cost-effectiveness ratio considered in this study to compare additional costs per unit of additional outcome, the return on investment with discounted cash flows, and the budgetary impact analysis for a given horizon and payer. The toolkit was used for scenario analysis: comparing baseline and behaviourally enhanced options, incorporating coverage, intervention acceptance and response elasticity.

The transmission channels from policy to economy work through a sequential chain: "tool – mechanism – behaviour – change – clinical outcomes – economic impact". Default recordings, patient navigation, notifications and feedback to clinicians increased preventive care attendance, adherence to therapy and compliance with protocols, which reduced late readmissions and re-occurrences, and thus reduced costs and unproductive days, boosting productivity and tax revenues (Thaler & Sunstein, 2021). Alignment of this chain with monitoring indicators (behavioural, clinical, economic) ensured attribution of effects and programme manageability. The institutional conditions for scaling up required a reliable data infrastructure (unified identifiers, timely analytics), transparent ethics and privacy rules, and operational frameworks for local experiments with subsequent scaling up of working solutions. From the perspective of public finance, fiscal sustainability assessment should exceed the scope of medical expenditures and cover costs and benefits at the level of the entire economy: changes in the wage bill, tax base, and social disability payments (Roshylo, 2023).

The implementation roadmap should include five steps. First, a behavioural diagnosis of barriers for patients and providers, with hypotheses of the tool, mechanism, and indicator. Next, pilot trials with an integrated system of indicators (behavioural, clinical, economic) and ethical oversight. The next step was an analysis of ICER/ROI and budgetary impact to select the optimal configuration. The fourth step was scaling up based on the principles of responsible use of behavioural approaches and built-in monitoring. And lastly, the final step was regular "follow-up audits" of procedures and updating of incentives to prevent the effects from fading. For providers, key KPIs should focus on outcomes, not just volumes: proportion of healthy people in the assigned population, coverage of preventive care within recommended timeframes, rate of unnecessary procedures, adherence to protocols, and rate of avoidable hospitalisations. Such indicators combine behavioural markers (intention, compliance) with health outcomes and costs, creating an incentive for preventive medicine and risk management at the population level. Given the risks of unequal impacts, policies should include stratification by age, gender, socioeconomic group, and digital access to target groups with lower health-literacy linkages and higher barriers to access (Organisation for Economic Co-operation and Development, 2022). This improved both efficiency and equity and stabilised the fiscal impact through wider coverage and smaller gaps in outcomes.

In summary, investment in integrated behavioural tools was not just a mechanism for improving communication, but also a regulator of changing the trajectories of supply and demand for healthcare, which translated into higher productivity and sustainable public finances. Sustainable implementation required a combination of evaluation methods (ICER, ROI, budgetary impact), a mature data infrastructure, and a clear ethic of applying behavioural approaches in public policy. It was necessary to ensure that management steps were benchmarked against a standard and that the criteria for termination or scaling up were predefined. The monitoring system should include the intention and implementation of the action, timeliness of referrals, recurrence, adherence to protocols, ICER, ROI, and budgetary impact.

Discussion

The principle of behavioural tools was primarily to reduce the "cost of inaction" and operational barriers. Automatic appointments for preventive services and reminders with clear details of the time, place and circumstances of the action consistently increased attendance at check-ups and vaccinations. It was possible to conclude that the presence of reminders increased attendance compared to no reminders, and at the same time was a more cost-effective solution than phone calls, i.e., it had a better effect at a lower cost to the payer. A. Barbaroux & I. Serati (2022) demonstrated in their study, how a behavioural tool can simultaneously increase coverage and maintain an ethical balance of soft power. The authors conducted an analysis among medical interns in Nice, applying an "opt-out" approach to flu vaccination: participants were immediately offered a specific time and place, with the right to refuse or reschedule. As a result, the study found that the group that was nudged

had higher immunisation rates and, at the same time, high acceptability of the intervention in terms of autonomy of choice. The design and size of the sample, as well as the analysis of acceptability (including the sense of control), provided good reasons to consider the opt-out method relevant for other professional groups.

Default options (when a visit or vaccination was scheduled automatically, and refusal required an additional action) increased coverage without coercion. Analysing local experiments in large practices, it was possible to see an increase in vaccination rates from simply introducing default appointments without displacing vaccinations to other channels. This shown that choice architecture can change behaviour even without financial incentives. A randomised comparison of emails with a ready-made customised appointment versus a standard invitation to self-booking by K. Tentori *et al.* (2022) showed a statistically significant increase in reach in the "default appointment" group. The study explained the effect by reducing behavioural inertia and minimising operational barriers, and emphasised that some of the indecisive were not "convinced opponents", but rather tended to postpone action. This meant that a choice architecture can deliver gains without price or regulatory coercion. This directly supported the thesis that default records were effective in prevention policy.

At the level of treatment adherence, simple planning prompts and regular reminders bridge the gap between intention and action. This, in turn, was subsequently reflected in clinical trajectories: timely referrals, completed courses of therapy, and fewer "lost" patients. According to I. Gurol-Urganci *et al.* (2013), patient navigation programmes have been shown to have higher screening completion rates and shorter time to diagnosis, meaning that behavioural changes translated into earlier detection of disease and potentially lower intensity of further treatment. Behavioural interventions were also changing providers' clinical decisions. Cluster randomised trials with "comparative feedback", rationale for prescribing and suggested alternatives had demonstrated a significant reduction in the proportion of unnecessary antibiotics in primary care without compromising patient outcomes. The study by U. Konradt *et al.* (2022) was a classic example of how social norms adjust practice at a low cost of intervention. In clinical medicine, it was also possible to observe, how default tools influence prescribing and the scope of interventions. According to G. Saposnik (2019), this led to systematically lower prescribed doses without an increase in repeat visits. It was worth noting that this also reduced the risks and costs associated with overprescribing.

Reducing transaction costs should be considered as a separate channel of influence. L. Tian *et al.* (2022) noted that simplified access routes, standardised options, and transparent "next step" steps reduce missed appointments and delayed hospitalisations. Pre-appointment reminders and clear recording interfaces directly reduced patient time wastage, as evidenced by improved turnout and time performance in navigation apps. At the same time, K. Werner *et al.* (2023) emphasised the heterogeneity of effects and the importance of context (type of service, time interval, message wording), which required local testing and customisation. From a policy perspective, this supported the thesis of "reducing transaction costs" as a separate channel of influence on access and timeliness of care. The study presented a systematic review and meta-analysis of behavioural interventions to reduce no-shows. The generalised estimates shown a steady positive effect of reminders and nudges (messages/letters, messages with clear instructions, simple comment mechanisms), and the cost of such measures, especially for digital channels, was usually lower than for phone calls or additional staff.

The meta-analysis by H.D. Nelson *et al.* (2025) summarised the evidence on "patient navigation" in the context of breast and cervical cancer screening. The study determined that navigation services increased the likelihood of getting screened and completing the steps of the screening process compared to alternatives. From the perspective of behavioural economics, navigation reduced the so-called "friction" process (searching, coordinating, recording, reminding), translated intentions into action, and, as a result, shifted clinical trajectories towards early detection, which had reasonable economic consequences (fewer complications, lower intensity of treatment). The study provided quantitative support for the assertion of a separate channel of influence for reducing transaction costs of access. Sustainability and scalability depend on reinforcement. Some of the effects of nudges faded without repetition of the stimulus. At the same time, programmes with booster sessions or social support elements demonstrated better longevity of impact on behaviour and sometimes on health events in the long term, as evidenced by D.D. Reed *et al.* (2022). This implied the need to design interventions as cyclical processes with planned "feeding" of the effect. Instead, a randomised trial by J.F. Steiner *et al.* (2018) assessed, how the number and timing of automated reminders affect missed appointments in primary care. Compared to a single reminder three or one day before the appointment, a combination of two reminders (three days and one day) statistically reduced the proportion of no-shows without compromising satisfaction with the visit. From the perspective of behavioural economics, this supported the thesis of "feeding" intention: the first reminder removed planning barriers and gave time to adjust the schedule, while the second kept the action in the field of attention at a time close to the event. Operationally, the intervention should be low-cost and provide additional gains, where the costs to the system were greatest in groups at risk of no-shows; this made the strategy attractive for scaling up, although the authors caution about external generalisability outside the integrated system, where the study was conducted.

At that time, M. de Gier *et al.* (2023) investigated the effectiveness of a "booster" support programme after cognitive behavioural therapy in patients with multiple sclerosis-related fatigue in a randomised controlled trial. The addition of mixed booster components helped to better maintain the effect achieved in the long term compared to usual care: fatigue and related functioning scores deteriorated more slowly, and the difference between the groups was maintained. From the perspective of behavioural economics, this empirically supported the "sustaining" thesis: even effective initial interventions need cyclical support to avoid fading, and this support can be organised in low-cost components (short sessions/digital reminders), which have direct implications for scaling up and budget planning. Robustness of conclusions required attention to external generalisability and variation in coverage. Even for widely implemented instruments (including checklists), the impact varies by individual subjects. According to C. Bao & I.R. Bardhan (2024), multicentre studies have linked checklist implementation to lower complications and mortality, indicating the importance of organisational context, team culture, and quality of implementation. Scientists K. Bielka *et al.* (2023) evaluated the effectiveness of the World Health Organisation checklists for the safety of surgery and anaesthetic equipment in war-affected, resource-limited settings in a prospective two-group, multicentre study. The introduction of standardised checklists was associated with improved process indicators (completeness of preoperative checks, compliance with key safety steps) and a reduction in the incidence of complications/critical incidents compared to control units. The study was relevant for its external generalisability: even in stressful, low-resource contexts, hardwired tools such as checklists align practice and deliver measurable benefits, which was consistent with a priority on tools that reduced variability and unnecessary costs.

A study of insurance behaviour and plan selection by J.W. Ely & M.A. Graber (2015) found that people with lower insurance literacy were more likely to make poor choices, overpaying or choosing dominantly worse options. Low-cost "tip sheets" and changes in the architecture of choice (ordering, grouping of options) reduced such mistakes and increased transitions to the best plans for a particular group. This became a relevant lesson for targeting communications and information presentation formats in health programmes. A study conducted in the UK by N. Gold *et al.* (2022) found no decrease in antibiotic prescribing after the mailing to practices with a tendency to increase prescriptions. This was a substantial clarification for policy, as it suggested that "social feedback" alone does not guarantee an effect in any context. What matters was the targeting (who was addressed), the timing of the intervention, the intensity and the combination with other elements (checklist, clinical guidelines, rationale for prescribing). This was a cautionary marker: social norms were a powerful, but not universal tool, and their effect depended on the underlying dynamics of practice and the quality of implementation. So, it was worth noting that, when the "tool – mechanism – behaviour change – clinical outcome – economic impact" chain was built correctly, behavioural approaches pay a double dividend: better health outcomes and more efficient costs. Standardised records and reminders increase preventive care coverage, comparative feedback and checklists made clinical decisions more consistent, and simplified routes reduce patient time. Together, this translated into lower costs for complications, fewer readmissions, and better economic metrics for payers, provided that vulnerable groups were targeted and the effect was sustained over time.

Conclusions

The study provided a holistic view of the integration of behavioural instruments into health economic policy and confirmed their effectiveness as a channel for reducing wasteful spending and improving programme performance. In particular, the analysis of empirical data showed that standardised records, clear messages and reminders consistently increased the coverage of preventive examinations and vaccinations, while the use of social norms and comparative feedback reduced the share of unjustified prescriptions. Clinical outcomes confirmed the improvement in quality of care, including increased adherence to treatment, reduced readmissions, and decreased operational errors using checklists and structured prompts. At the system level, transactional barriers were reduced through transparent routes and digital recording interfaces, which lowered patient time and increased the timeliness of appointments.

The economic dimension of the interventions was equally significant: Incremental Cost-Effectiveness Ratio indicator showed that even low-cost interventions were economically feasible due to avoided complications and improved quality of life. On average, the Return on Investment of the programmes exceeded the cost of implementation, and the analysis of the budgetary impact showed that resources could be reallocated from inpatient to outpatient care without increasing overall spending. At the same time, the reduction of unproductive days and the decrease in productivity losses confirmed the positive impact of behavioural mechanisms on macroeconomic indicators. The proposed conceptual model combined the causal chain of "tool – mechanism – behavioural – change – clinical outcome – economic effect" with an integrated system of indicators covering behavioural, clinical and financial metrics. This ensured that results can be attributed and policy adjustments can be made based on validated data. The recommendations included launching pilot behavioural interventions with a tool – mechanism – indicator logic and a monitoring system that combined behavioural, clinical and economic indicators, with regular feedback. At the same time, it would be advisable to shift funding incentives to results,

using Key Performance Indicators and soft instruments, and to introduce booster components to maintain the effect. The final step would be to institutionalise the "plan – analyse – correct" cycle as a sustainable management practice. A limitation of the study was the dependence of the conclusions on the assumptions in the evaluation parameters (Incremental Cost-Effectiveness Ratio, Return on Investment, budgetary impact), which may limit their direct transferability to other institutional and clinical contexts. Further research should focus on testing the sustainability of effects in the long term, developing scaling-up scenarios, and integrating behavioural indicators into the official monitoring system of government programmes. Attention should also be paid to segmenting target groups according to age, socioeconomic and cultural differences, which would improve the targeting and effectiveness of health interventions.

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Conflict of Interest

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Інтеграція поведінкових інсайтів у загальну теорію економічної політики у сфері охорони здоров'я

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Анотація. Метою дослідження було концептуалізувати роль механізмів поведінкової економіки як складової сучасної теорії економічної політики у сфері охорони здоров'я. У роботі використано методи моделювання причинно-наслідкового ланцюга "інструмент – механізм – зміна поведінки – клінічні результати – економічний ефект", контент-аналізу матеріалів міжнародних досліджень, абстрагування системи індикаторів (поведінкові, клінічні, економічні), систематичного аналізу показників оцінювання ефективності (показник Incremental Cost-Effectiveness Ratio та рентабельності інвестицій, аналіз бюджетного впливу). Отримані результати продемонстрували, що структуровані нагадування, планувальні підказки, соціальні норми та порівняльний зворотний зв'язок для провайдерів зменшують відкладені звернення, підвищують прихильність до лікування та скорочують надмірні процедури, що відображається у нижчій інтенсивності дорогих епізодів догляду, стабільнішій якості послуг і скороченні непрямих втрат продуктивності. Визначено макроекономічні та фіскальні наслідки інтеграції поведінкових інсайтів у загальну теорію економічної політики, серед яких покращення здоров'я населення, яке впливає на тривалість життя та захворюваність, зростання відвідуваності та продуктивності, вплив на макроекономіку, що означає більший обсяг виробництва. Також, до них належало зростання зайнятості та податкових надходжень, менші витрати на допомогу по непрацездатності. Запропоновано дорожню карту впровадження, яка поєднувала етичні принципи використання поведінкових інструментів, вимоги до інфраструктури даних і механізми регулярного моніторингу ("планування – збір – аналіз – зворотний зв'язок – корекція"), орієнтуючи фінансування на результати (ключові показники ефективності: охоплення профілактикою, частка здорового населення, частота надмірних призначень). Практична цінність полягає у наданні економічно-обґрунтованих підстав для перерозподілу ресурсів у бік превентивної медицини, підвищення вартісної ефективності видатків та посилення довгострокової фіскальної стійкості через канали відвідуваності, продуктивності праці та зайнятості

Ключові слова: фінансування охорони здоров'я; опції за замовчуванням; соціальні норми; фреймінг повідомлень; система індикаторів оцінювання; бюджетний вплив; державна політика