

Veille scientifique en économie de la santé

Watch on Health Economics Literature

Novembre 2021 / November 2021

Assurance maladie	<i>Health Insurance</i>
Démographie	<i>Demography</i>
E-santé – Technologies médicales	<i>E-health – Medical technologies</i>
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Géographie de la santé	<i>Geography of health</i>
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Méthodologie – Statistique	<i>Methodology - Statistics</i>
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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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Health Insurance**► Medicaid Expansion Reduced Uninsured Surgical Hospitalizations and Associated Catastrophic Financial Burden**ALBRIGHT B. B., CHINO F., CHINO J. P., *et al.*
2021**Health Affairs 40(8): 1294-1303.**<https://doi.org/10.1377/hlthaff.2020.02496>

An important function of health insurance is protecting enrollees from excessively burdensome charges for unanticipated medical events. Unexpected surgery can be financially catastrophic for uninsured people. By targeting the low-income uninsured population, Medicaid expansion had the potential to reduce the financial risks associated with these events. We used two data sources (state-level data for forty-four states and patient-level data for four states) to estimate the association of Medicaid expansion with uninsured surgical hospitalizations among nonelderly adults. Uninsured surgery cases were typically admitted through the emergency department often for common emergency procedures and 99 percent of them were estimated to be associated with financially catastrophic visit charges. We found that Medicaid expansion was associated with reductions in both the share (6.20 percent) and the population rate (7.85 per 10,000) of uninsured surgical discharges in expansion versus nonexpansion states. Our estimates suggest that in 2019 alone, adoption of Medicaid expansion in nonexpansion states could have prevented more than 50,000 incidences of catastrophic financial burden resulting from uninsured surgery.

► Creating Universal Health Care in Ireland: A Legal ContextLAU M., LARKIN C., HARTY M., *et al.*
2021**Health Policy 125(6): 777-785.**<https://doi.org/10.1016/j.healthpol.2021.04.003>

In this paper we establish a working definition of, and develop a legal rationale for, the insertion of a constitutional Right to Health (RTH) protection in the Constitution of Ireland. We propose that a legal framework exists for the judicial enforcement of a right to health in Ireland, as based on parallels drawn between

Irish case law and that of RSA, a comparable common law constitutional democracy with a developed jurisprudential approach to its constitutional RTH. When modelled after precedential international provisions, this right strengthens and defends health policy goals (such as universal health care) through a common-law system of governmental accountability. Additionally, national rights to health have observable correlations with improved public health, and it stimulates institutional initiatives. The 1937 Constitution of Ireland includes several personal, social, and economic rights, and a RTH would complement the existing right to primary education as a socio-economic right. We note these considerations were discussed during the legislative proposal made in the 32nd Dáil for a constitutional RTH, which emerged in response to Ireland's ongoing efforts toward health policy reform.

► Democracies Linked to Greater Universal Health Coverage Compared with Autocracies, Even in an Economic RecessionTEMPLIN T., DIELEMAN J. L., WIGLEY S., *et al.*
2021**Health Affairs 40(8): 1234-1242.**<https://doi.org/10.1377/hlthaff.2021.00229>

Despite widespread recognition that universal health coverage is a political choice, the roles that a country's political system plays in ensuring essential health services and minimizing financial risk remain poorly understood. Identifying the political determinants of universal health coverage is important for continued progress, and understanding the roles of political systems is particularly valuable in a global economic recession, which tests the continued commitment of nations to protecting their health of its citizens and to shielding them from financial risk. We measured the associations that democracy has with universal health coverage and government health spending in 170 countries during the period 1990-2019. We assessed how economic recessions affect those associations (using synthetic control methods) and the mechanisms connecting democracy with government health spending and universal health coverage (using machine learning methods). Our results show

that democracy is positively associated with universal health coverage and government health spending and that this association is greatest for low-income countries. Free and fair elections were the mechanism primarily responsible for those positive associations.

Democracies are more likely than autocracies to maintain universal health coverage, even amid economic recessions, when access to affordable, effective health services matters most.

Démographie

Demography

► **La dynamique de la population de la France au XXI^e siècle : un changement de paradigme démographique ?**

DUMONT G.-F.
2021

Population & Avenir 754(4)

<https://www.cairn.info/revue-population-et-avenir-2021-4-page-3.htm>

Jusqu'à aujourd'hui, la France métropolitaine a toujours pu compter, sauf en de très rares circonstances, sur un net excédent des naissances sur les décès. Mais le temps ne joue guère en faveur de cet excédent démographique naturel. Et les évolutions récentes de la mortalité et de la natalité pourraient anticiper le moment d'un renversement de paradigme démographique : un déficit naturel structurel. Depuis le début des années 2000, le nombre de décès est logiquement en augmentation compte tenu du vieillissement de la population et en dépit de la hausse moyenne de l'espérance de vie des personnes âgées. Toutefois, cette tendance est marquée d'irrégularités notamment en raison de l'intensité mortifère des gripes saisonnières. Le phénomène le plus notable est la hausse des décès due à la canicule en 2003, suivie d'une nette baisse l'année suivante, s'expliquant par le fait que nombre de décès de l'année 2003 ont concerné des personnes dont la mort serait survenue l'hiver suivant. À la fin des années 2000, la stagnation des décès tient à la hausse moyenne de l'espérance de vie des personnes âgées, sachant que les plans canicules de protection des personnes âgées ont pu exercer des effets positifs. Avec les années 2010, l'augmentation du nombre annuel des décès se poursuit avec l'importance de la gérontocroissance, c'est-à-dire des effectifs plus nombreux des générations arrivant à l'âge de 65 ans, nées dans la période de renouveau démographique postérieure à la Seconde Guerre mondiale.

► **L'immigration dans les campagnes françaises : des effectifs limités mais des effectifs qui ne cessent de se diversifier**

FROMENTIN J. ET PISTRE P.
2021

Population & Sociétés(591)

<https://www.ined.fr/fr/publications/editions/population-et-societes/immigration-dans-campagnes-francaises-des-effectifs-limites-mais-des-origines-qui-ne-cessent-de-se-diversifier/>

Que représente aujourd'hui l'immigration dans les campagnes françaises? Comment se répartit-elle sur le territoire national et quelles sont ses caractéristiques? Exploitant les recensements de population, Julie Fromentin et Pierre Pistre examinent comment la population immigrée a évolué dans les campagnes françaises depuis les années 1970, à la fois en nombre, en part de la population, et dans ses origines.

E-santé – Technologies médicales

E-health – Medical technologies

► **Satisfaction des médecins généralistes concernant leurs outils numériques : méritons-nous mieux ?**

ABRIAL Y. ET AZERAD D.
2021

Médecine : De La Médecine Factuelle à Nos Pratiques 17(4): 168-174.

https://www.jle.com/fr/revues/med/e-docs/satisfaction_des_medecins_generalistes_concernant_leurs_outils_numeriques_meritons_nous_mieux__320245/article.phtml

Selon J.L. Funck Brentano, pionnier de l'informatique médicale en 1980, l'informatique devait « favoriser un retour en force de l'humanisme en santé », en permettant au médecin de se consacrer au dialogue intimiste qui fait toute la force du « colloque singulier ». Ces évolutions devaient donc permettre de faciliter la pratique, d'échanger, de se coordonner, et d'offrir une meilleure prise en charge pour les patients. Mais les médecins généralistes sont-ils satisfaits de leurs outils numériques (logiciels métiers, agendas numériques, téléconsultation) et quelles sont leurs principales attentes ?

► **La gestion des données de santé par le Heath Data Hub : le recours à la société Microsoft, entre risques et précautions**

BÉVIÈRE-BOYER B.
2021

Droit, Santé et Société 3(3): 42-48.

<https://www.cairn.info/revue-droit-sante-et-societe-2021-3-page-42.htm>

Alors même que la nouvelle plateforme des données de santé française, appelée aussi Heath Data Hub est dans la tourmente, puisque critiquée pour avoir choisi la société Microsoft, notamment au regard de l'arrêt Schrems de la Cour de Justice de l'Union européenne du 16 juillet 2020, elle reste soutenue par le Conseil d'État lors de son ordonnance du 13 octobre 2020. L'étude de cette affaire permet de mieux appréhender les risques, ainsi que les précautions à prendre pour la gestion des données de santé au niveau national et communautaire.

► **Santé et intelligence artificielle, quelle(s) révolution(s) ? Le défi des échanges interdisciplinaires**

BÉVIÈRE-BOYER B.
2021

Droit, Santé et Société 2(2): 3-7.

<https://www.cairn.info/revue-droit-sante-et-societe-2021-2-page-3.htm>

Toute la question est de savoir si l'intelligence artificielle dans le domaine de la santé doit ou non être appréhendée comme une révolution, si elle opère des transformations dans la conception de la santé, dans les modalités de prise en charge, dans les relations entre les différents acteurs, entre les pays, etc. Outre cette période particulière de pandémie qui mène à réfléchir collectivement sur la ou les révolution(s) potentielles de la santé par les moyens de l'intelligence artificielle, les réflexions sur les transformations actuelles et à venir des notions et des pratiques sont essentielles pour mieux mieux l'appréhender, dans l'interdisciplinarité et au niveau international sur cette question essentielle.

► **Les intelligences artificielles comme outils au service de la santé : limites et perspectives**

BOUCHNITA A. ET LLORED J.-P.
2021

Droit, Santé et Société 2(2): 36-49.

<https://www.cairn.info/revue-droit-sante-et-societe-2021-2-page-36.htm>

Sur la base d'exemples illustrant l'utilisation d'intelligences artificielles dans le domaine de la santé et, en particulier, d'une intelligence artificielle dont nous sommes les concepteurs, ce texte analyse, en mobilisant une démarche épistémologique, les limites de ces utilisations et les perspectives qu'elles peuvent, au-delà de ces limites, ouvrir pour les praticiennes et les praticiens de la médecine.



► **Telehealth in Primary Healthcare :
A Portrait of its Rapid Implementation
during the COVID-19 Pandemic**

BRETON M., DEVILLE-STOETZEL N., GABOURY I., *et al.*
2021

Healthcare Policy 17(1): 73-90.

<https://www.longwoods.com/content/26576/telehealth-in-primary-healthcare-a-portrait-of-its-rapid-implementation-during-the-covid-19-pandemi>

This study documents the adoption of telehealth by various types of primary healthcare (PHC) providers working in teaching PHC clinics in Quebec during the COVID-19 pandemic. It also identifies the perceived advantages and disadvantages of telehealth. Method : A cross-sectional study was conducted between May and August 2020. The e-survey was completed by 48/50 teaching primary care clinics representing 603/1,357 (44%) PHC providers. Results : Telephone use increased the most, becoming the principal virtual modality of consultation, during the pandemic. Video consultations increased, with variations by type of PHC provider: between 2% and 16% reported using it « sometimes. » The main perceived advantages of telehealth were minimizing the patient's need to travel, improved efficiency and reduction in infection transmission risk. The main disadvantages were the lack of physical exam and difficulties connecting with some patients. Conclusion : The variation in telehealth adoption by type of PHC provider may inform strategies to maximise the potential of telehealth and help create guidelines for its use in more normal times.

► **La protection des données personnelles
de santé en France et en Europe
par le Règlement Général sur la Protection
des Données (RGPD)**

CAYOL A.
2021

Droit, Santé et Société 3(3): 49-54.

<https://www.cairn.info/revue-droit-sante-et-societe-2021-3-page-49.htm>

Le développement du numérique dans le domaine de la santé a profondément modifié la question de la protection des informations relatives aux patients en permettant de conserver des masses de données importantes, d'y avoir accès plus facilement et de les transmettre plus largement. L'accès à toutes ces données présente un intérêt majeur pour les tiers dits « intéressés ». Afin de préserver les droits et libertés

fondamentaux, le traitement des données à caractère personnel a rapidement été encadré en France, puis en Union européenne. Du fait de leur lien étroit avec la personne concernée, les données de santé font l'objet, au sein de l'Union européenne, d'une protection renforcée par rapport aux autres données à caractère personnel. Le RGPD offre une avancée notable sur ce point : définissant pour la première fois expressément les données de santé, il en retient en effet une conception extensive. Se saisissant de la marge de manœuvre laissée aux États membres par le RGPD, la France a, en outre, prévu des exigences supplémentaires pour leur traitement dans un certain nombre de cas.

► **Le développement de l'IA dans le domaine
de la santé : une révolution pour le droit
de la responsabilité civile ?**

CAYOL A.
2021

Droit, Santé et Société 3(3): 22-28.

<https://www.cairn.info/revue-droit-sante-et-societe-2021-3-page-22.htm>

Le développement des usages de l'intelligence artificielle (IA) dans le domaine de la santé interroge quant à l'adaptation des règles juridiques applicables en cas de dommage en résultant. Le changement de paradigme serait tel, selon certains, avec l'avènement d'une IA de plus en plus « forte », qu'une véritable « révolution » du droit de la responsabilité civile serait nécessaire : la création d'un régime de responsabilité sui generis du fait de l'IA s'imposerait, voire même la consécration de la responsabilité de l'IA elle-même, à laquelle serait reconnue la personnalité juridique. Rien ne justifie en réalité une telle révolution : tant le droit commun de la responsabilité que le régime spécial de responsabilité du fait des produits défectueux sont susceptibles d'évoluer par de simples ajustements afin de répondre aux enjeux soulevés par le recours croissant à l'IA.

► **Le périple de l'éthique de l'Intelligence Artificielle dans la révolution en cours des systèmes de soins**

DENIS C.
2021

Droit, Santé et Société 3(3): 17-21.

<https://www.cairn.info/revue-droit-sante-et-societe-2021-3-page-17.htm>

L'Intelligence Artificielle semble être une clé de voute technologique pour mettre en place de nouveaux paradigmes en médecine, rendus nécessaires pour assurer au plus grand nombre un accès à un système de soin de qualité. Depuis 2010, le renouveau de l'Intelligence Artificielle est porté par les fortes capacités prédictives de l'apprentissage machine profond. Cela nécessite de considérer plusieurs problèmes éthiques : d'une part liés à l'utilisation de réseaux de neurones (effet boîte noire par exemple), ou d'autre part hérités de la formalisation de la médecine en utilisant notamment la méthodologie statistique. Un travail de recherche interdisciplinaire en cours réunissant des informaticiens et des philosophes a pour objectif de fournir des explications éthiques des prédictions de réseaux de neurones. Malgré ces travaux, la crise sanitaire actuelle montre que les méthodes d'apprentissage profond bien qu'utiles ne sont pas la panacée pour comprendre un virus inconnu lorsqu'il n'existe pas de base de données historiques le concernant. Notre piste de recherche est d'utiliser l'apprentissage machine comme un médiateur entre la connaissance médicale actuelle et les observations provenant du monde sensible pour aider à la compréhension de nouveaux phénomènes.

► **Rapport 21-08. La téléconsultation en médecine générale : une transformation en profondeur dans la façon de soigner**

JAURY P., LARANGOT-ROUFFET C., GAY B., *et al.*
2021

Bulletin de l'Académie Nationale de Médecine.

<https://doi.org/10.1016/j.banm.2021.07.008>

Fortement encouragée par les arrêtés de 2018 qui définissent les actes de téléconsultation pris en charge par l'Assurance Maladie, la téléconsultation médicale s'est ancrée dans la pratique des médecins généralistes notamment à la faveur du confinement et de l'état d'urgence sanitaire. La téléconsultation a été utile pour éviter des prises de risque vis-à-vis de la COVID-19,

pour assurer la surveillance des patients atteints de maladies chroniques ou pour améliorer l'accès aux soins. Au quotidien, à côté de ces avantages, il existe aussi des aléas de fonctionnement et des inconvénients qui méritent d'être évalués. Il faut s'interroger sur les conséquences de « cette autre façon de pratiquer la médecine » avec l'absence de l'examen clinique et la modification de la relation médecin-malade.

► **L'appropriation de la télémédecine dans les EHPAD : entre contraintes organisationnelles et engagements individuels**

LANGLOIS E. ET ABRAHAM M.
2021

Revue française des affaires sociales(2): 237-254.

<https://www.cairn.info/revue-francaise-des-affaires-sociales-2021-2-page-237.htm>

Le développement de la télémédecine est devenu un enjeu dans le système de soins, en particulier dans les Ehpads où il est important pour les résidents de pouvoir accéder rapidement à des consultations spécialisées tout en préservant une bonne qualité de vie. Cet article présente une étude qui montre les difficultés d'installation de la télémédecine dans les Ehpads et interroge les conditions d'appropriation de cet outil par les professionnels du soin. Basée sur une étude multisite et 25 entretiens semi-directifs, l'enquête montre que ces établissements évoluent dans un contexte organisationnel fragile qui rend difficile l'encastrement de la télémédecine dans les pratiques et routines professionnelles.

► **The Shared Medical Record, a Digital Health Record For All**

MERLIÈRE Y.
2020

Soins 65(842): 29-32.

In July 2016, the National Health Insurance re-launched the shared medical record, a tool for sharing information between health professionals and patients. Its use has been growing among doctors for more than a year now, and more healthcare institutions are rolling it out.



► **La relation de soin à l'épreuve de l'intelligence artificielle : rupture ou continuité ?**

QUESNE A.
2021

Droit, Santé et Société 2(2): 55-60.

<https://www.cairn.info/revue-droit-sante-et-societe-2021-2-page-55.htm>

L'étude de la relation de soin invite à l'analyse des principes fondamentaux qui la régissent. Certains principes, bousculés par le développement de l'intelligence artificielle, sont contraints de s'adapter, tandis que de nouveaux principes vont devoir faire leur apparition. La révolution n'est et ne doit pas être complète en la matière, mais l'intelligence artificielle bouleverse nécessairement la relation de soin. On assiste alors à la recherche d'un équilibre entre le rôle du médecin et celui de l'intelligence artificielle, mais également s'agissant des droits et des devoirs du patient en présence de l'intelligence artificielle, nouvel acteur de la relation de soin.

► **Health Information Technology to Improve Care For People with Multiple Chronic Conditions**

SAMAL L., FU H., DJIBRIL C., *et al.*
2021

Health Services Research na/na

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13860>

The aim of this study is to review evidence regarding the use of Health Information Technology (health IT) interventions aimed at improving care for people living with multiple chronic conditions (PLWMCC) in order to identify critical knowledge gaps. Data sources We searched MEDLINE, CINAHL, PsycINFO, EMBASE, Compendex, and IEEE Xplore databases for studies published in English between 2010-2020. Study Design We identified studies of health IT interventions for PLWMCC across three domains: self-management support, care coordination, and algorithms to support clinical decision-making. Data was extracted independently by two reviewers. Principal Findings The search yielded 1907 articles; 44 were included. Nine randomized controlled trials (RCTs) and 35 other studies including quasi-experimental, usability, feasibility, qualitative studies, or development/validation studies of analytic models. Five RCTs had positive results and the remaining four RCTs showed that the interventions had no effect. The

studies address individual patient engagement and assess patient-centered outcomes such as quality of life. Few RCTs assess outcomes such as disability and none assess mortality. Conclusions Despite a growing body of literature on health IT interventions or multi-component interventions including a health IT component for chronic disease management, current evidence for applying health IT solutions to improve care for PLWMCC is limited. The body of literature included in this review provides critical information on the state of the science as well as the many gaps that need to be filled for digital health to fulfill its promise in supporting care delivery that meets the needs of PLWMCC.

► **The Geographies of Digital Health – Digital Therapeutic Landscapes and Mobilities**

THOMPSON M.
2021

Health & Place 70: 102610.

<https://doi.org/10.1016/j.healthplace.2021.102610>

Digital technologies have long impacted the field of health, causing fundamental changes for the geographies of the production, movement, and consumption of health. Despite this, there is limited health geography engagement with digital health, and an understanding of how digital health affects the spatialities of health remains underdeveloped. Here, using autoethnography, I reflect on personal encounters with digital health in the UK to initiate analytical attention into the geographies of digital health. I demonstrate that digital health technologies are interconnected and increasingly structure access to health, impacting the equality of health; and that digital health disrupts existing, and creates new, therapeutic landscapes and mobilities.

► **L'intelligence artificielle en santé, nouveau champ de la bioéthique**

TOURAINÉ J.-L.
2021

Droit, Santé et Société 3(3): 3-7.

<https://www.cairn.info/revue-droit-sante-et-societe-2021-3-page-3.htm>

Le développement rapide de l'intelligence artificielle dans le domaine sanitaire a déjà offert des progrès importants au bénéfice des patients (diagnostic, traitement, robotique...) comme de la santé publique et de la gestion du système de santé. Cette évolution impose

une réflexion éthique ainsi qu'un encadrement progressivement défini. La relation médecin-malade ne doit pas être perturbée mais au contraire renforcée lorsque cet outil nouveau est introduit dans le processus de soins. L'identification de dérives possibles et leur

prévention, le risque d'inégalités additionnelles entre les divers types de populations, sont des considérations à mettre en regard des très importants avantages de l'IA dans le champ de la santé.

Covid

► **The Contribution of Teleconsultation and Isolation of Symptomatic Cases in Control of the COVID-19 Outbreak at a Military Base**

ALLONNEAU A., VILLENEUVE J. P., SEMPERE H., *et al.*
2021

Revue d'épidémiologie et de santé publique 69(4): 167-171.

<https://pubmed.ncbi.nlm.nih.gov/34119362>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8162725/>

The first wave of COVID-19 swept over France during the first quarter of 2020, leading to saturation of the health care system. We wished to study, in a French military medical unit assisting one of the country's largest armed forces populations, the impact of teleconsultation and the systematic isolation of all possible, probable and confirmed cases of COVID-19. This is a retrospective study carried out from March 9 to May 31, 2020 on the basis of our activity register. The variables collected included type of medical consultation procedure, occupational status, classification of cases and date of onset of first symptoms. We have paralleled our activity with that of SOS Médecins and the emergency departments of the Île-de-France region. During this period, 1719 episodes of care (teleconsultations or physical consultations) were recorded, of which 91% (n=1561) were linked to COVID-19. We identified 598 «suspected» (possible and probable) and confirmed cases. «Isolated» teleconsultations (not followed by a face-to-face medical consultation, sample taking or necessitating the dispatch of prompt assistance) represented 86% of episodes of care (n=1482). Comparison of our activity and the number of new cases with the databases of SOS Médecins and the Île-de-France emergency services suggests that our isolation strategy was timely and effective. The contribution of teleconsultation was substantial and reassuring. Teleconsultation makes it possible to absorb a large volume of patients, is easy to implement, and entails no nosocomial risk. Isolation of infected patients should be a priority during an outbreak. Once it has become a

priority to rapidly bring an epidemic under control, this attitude must be extended to all symptomatic patients.

► **La saga Stop Covid, suite et fin ?**

BOURILLON C.
2021

Droit, Santé et Société 3(3): 38-41.

<https://www.cairn.info/revue-droit-sante-et-societe-2021-3-page-38.htm>

Face à une volonté gouvernementale de relancer l'application StopCovid, la clôture de la mise en demeure adressée par la CNIL au ministère de la santé, responsable de traitement, interroge. En effet le contrôle de l'autorité a démontré des failles, de l'outil de traçage de suivi et d'information des cas contacts au Covid 19, dans la protection et les droits des utilisateurs sur leurs données personnelles.

► **Prise en charge par téléconsultation des patients diabétiques dans le contexte de la pandémie de la COVID-19 : étude prospective observationnelle**

FLOCARD M., MEYER L., FABACHER T., *et al.*
2021

Médecine des Maladies Métaboliques 15(1): 24-32.

<https://doi.org/10.1016/j.mmm.2020.11.002>

La pandémie à coronavirus 2019 (COVID-19) a contraint les pouvoirs publics français à instaurer un confinement à domicile de la population, avec un impact potentiel sur l'équilibre glycémique des patients diabétiques. Dans ce contexte, la télé médecine semble être un outil pertinent pour assurer le suivi de ces patients. Nous avons réalisé une étude prospective observationnelle, aux hôpitaux universitaires de Strasbourg, ainsi que dans un cabinet libéral de la ville, afin d'évaluer l'équilibre glycémique à 3 mois de 491 patients diabétiques, suivis par téléconsultation (n=338) ou dont la consultation en présentiel a été reportée à 6 mois (n=153).

Des questionnaires de satisfaction patients et médecins ont été recueillis pour apprécier l'impact des actions de télé-médecine. À 3 mois, une réduction moyenne non significative de $-0,33\%$ du taux d'hémoglobine glyquée (HbA1c) était observée dans le groupe suivi par téléconsultation ($n=175$) contre $-0,13\%$ dans le groupe sans téléconsultation ($n=92$). Dans le groupe téléconsultation, l'HbA1c diminuait de $7,65\pm 1,19\%$ à $7,18\pm 0,9\%$ pour les patients suivis à l'hôpital ($n=97$), et de $7,28\pm 0,80\%$ à $7,11\pm 0,79\%$ pour les patients suivis en ville ($n=78$). Quarante-deux pour cent des patients se sont déclarés satisfaits de leur téléconsultation, posi-

tionnant la téléconsultation comme une alternative à une consultation en présentiel et la recommanderaient à un autre patient diabétique. Alors que sept diabéto-logues sur huit n'avaient jamais effectué de télécon-sultation, tous souhaitent continuer cette modalité de suivi après la crise sanitaire. Au regard des données manquantes — en lien avec les difficultés de recueil pendant la pandémie — la tendance à l'amélioration de l'équilibre glycémique observée dans le groupe télé-consultation doit être confirmée par une évaluation à 6 mois de l'équilibre glycémique des patients.

Économie de la santé

Health Economics

► Financial Burdens of Out-Of-Pocket Spending Among Medicare Fee-For-Service Beneficiaries: Role of the “Big Four” Chronic Health Conditions

BASU R. ET LIU H.
2021

Medical Care Research and Review : Ahead of pub.

<https://journals.sagepub.com/doi/abs/10.1177/10775587211032837>

While Medicare is the universal source of health care coverage for Americans aged 65 years or older, the program requires significant cost sharing in terms of out-of-pocket (OOP) spending. We conducted a retrospective study using data from 2016 to 2018 Medicare Current Beneficiary Surveys of elderly community-dwelling beneficiaries ($n=10,431$) linked with administrative data to estimate OOP spending associated with the “big four” chronic diseases (cardiovascular disease, cancer, diabetes, and chronic lung disease). We estimated a generalized linear model adjusting for predisposing, enabling, and need factors to estimate annual OOP spending. We found that beneficiaries with any of the “big four” chronic conditions spent 15% ($p < .001$) higher OOP costs and were 56% more likely to spend $\geq 20\%$ of annual income on OOP expenditure (adjusted odds ratio = 1.56; $p < .001$) compared with those without any of those conditions. OOP spending appears to be heterogeneous across disease types and changing by conditions over time.

► Improving Target Price Calculations in Medicare Bundled Payment Programs

CHER B. A. Y., GULSEREN B. ET RYAN A. M.
2021

Health Services Research 56(4): 635-642.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13675>

The aim of this study is to compare the predictive accuracy of two approaches to target price calculations under Bundled Payments for Care Improvement-Advanced (BPCI-A): the traditional Centers for Medicare and Medicaid Services (CMS) methodology and an empirical Bayes approach designed to mitigate the effects of regression to the mean. Data sources Medicare fee-for-service claims for beneficiaries discharged from acute care hospitals between 2010 and 2016. Study design We used data from a baseline period (discharges between January 1, 2010 and September 30, 2013) to predict spending in a performance period (discharges between October 1, 2015 and June 30, 2016). For 23 clinical episode types in BPCI-A, we compared the average prediction error across hospitals associated with each statistical approach. We also calculated an average across all clinical episode types and explored differences by hospital size. Data collection/extraction methods We used a 20% sample of Medicare claims, excluding hospitals and episode types with small numbers of observations. Principal findings The empirical Bayes approach resulted in significantly more accurate episode spending predictions for 19 of 23 clinical episode types. Across all

episode types, prediction error averaged \$8456 for the CMS approach versus \$7521 for the empirical Bayes approach. Greater improvements in accuracy were observed with increasing hospital size. Conclusions CMS should consider using empirical Bayes methods to calculate target prices for BPCI-A.

► **Impact of the Removal of Patient Co-Payments For Antiretroviral Therapy (ART) on Out-Of-Pocket Expenditure, Adherence and Virological Failure Among Australian Adults Living with HIV**

EVELYN L., LIMIN M., JOHN, D. W., *et al.*
2021

Health Policy 125(9): 1131-1139.

<https://doi.org/10.1016/j.healthpol.2021.07.002>

In 2015, New South Wales (Australia) removed patient co-payments for ART of HIV. We hypothesized the policy change would reduce overall out-of-pocket (OOP) healthcare expenditure, improve ART adherence, and better maintain HIV suppression. Methods: Using data from a national, 2-year prospective study of adults with HIV on ART (n = 364) (2013-2017), we compared OOP healthcare expenditure, ART adherence, and virological failure (VF) in participants subject to the co-payment policy change with participants from other jurisdictions who never paid, and who always paid, co-payments. We used fixed effects regression models to compare outcomes, and incidence rates for VF. Results : Although ART co-payments declined, there was no significant change in total OOP healthcare expenditure in participants ceasing co-payments compared to those who continued (adjusted coefficient 0.09, 95% CI -0.31 to 0.48). Co-payment removal did not significantly reduce suboptimal ART adherence (from 17.5% to 16.3%) or VF (from 5.0 to 3.7 episodes per-100-person-years). Participants in the lowest income group but not receiving concessional government benefits incurred a non-significant increase in total OOP healthcare expenses; while concessional participants experienced a significant increase in non-ART HIV healthcare costs after the policy changed. Conclusion : In this population, ART co-payments represented a small proportion of OOP healthcare expenditure. Its removal did not materially impact ART adherence or VF, although the study was not powered to detect these.

► **International Comparison of Health Spending and Utilization Among People with Complex Multimorbidity**

FIGUEROA J. F., PAPANICOLAS I., RILEY K., *et al.*
2021

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

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13708>

The objective of this study was to explore cross-country differences in spending and utilization across different domains of care for a multimorbid persona with heart failure and diabetes. Data Sources We used individual-level administrative claims or registry data from inpatient and outpatient health care sectors compiled by the International Collaborative on Costs, Outcomes, and Needs in Care (ICCONIC) across 11 countries: Australia, Canada, England, France, Germany, the Netherlands, New Zealand, Spain, Sweden, Switzerland, and the United States (US). Data Collection/Extraction Methods Data collected by ICCONIC partners. Study Design We retrospectively analyzed age-sex standardized utilization and spending of an older person (65–90 years) hospitalized with a heart failure exacerbation and a secondary diagnosis of diabetes across five domains of care: hospital care, primary care, outpatient specialty care, post-acute rehabilitative care, and outpatient drugs. Principal Findings Sample sizes ranged from n = 1270 in Spain to n = 21,803 in the United States. Mean age (standard deviation [SD]) ranged from 76.2 (5.6) in the Netherlands to 80.3 (6.8) in Sweden. We observed substantial variation in spending and utilization across care settings. On average, England spent \$10,956 per person in hospital care while the United States spent \$30,877. The United States had a shorter length of stay over the year (18.9 days) compared to France (32.9) and Germany (33.4). The United States spent more days in facility-based rehabilitative care than other countries. Australia spent \$421 per person in primary care, while Spain (Aragon) spent \$1557. The United States and Canada had proportionately more visits to specialist providers than primary care providers. Across almost all sectors, the United States spent more than other countries, suggesting higher prices per unit. Conclusion Across 11 countries, there is substantial variation in health care spending and utilization for a complex multimorbid persona with heart failure and diabetes. Drivers of spending vary across countries, with the United States being the most expensive country due to high prices and higher use of facility-based rehabilitative care.

► **Higher Medicare Expenditures Are Associated with Better Integrated Care As Perceived by Patients**

KERRISSEY M. J., FREAN M., TRABOULSI A. A.-R., *et al.*
2021

Medical Care 59(7): 565-571.

<https://doi.org/10.1097/mlr.0000000000001558>

Integrated care that is continuous, coordinated and patient-centered is vital for Medicare beneficiaries, but its relationship to health care expenditures remains unclear. Research Objective: This study explores—for the first time—the relationship between integrated care, as measured from the patient’s perspective, and health care expenditures. Methods: Subjects include a sample of continuously eligible fee-for-service Medicare beneficiaries (n = 8807) in 2015. Analyses draw on 7 previously validated measures of patient-perceived integrated care from the 2015 Medicare Current Beneficiary Survey. These data are combined with 2015 administrative utilization data that measure health care expenditures. Relationships between patient-perceived integrated care and costs are assessed using generalized linear models with comprehensive control measures. Results: Patients who perceive more integrated care have higher expenditures for many, but not all, cost categories examined. Aspects of integrated care pertaining to primary provider and specialist care are associated with higher costs in several areas (particularly inpatient costs associated with specialist knowledge of the patient). Office staff members’ knowledge of the patient’s medical history is associated with lower home health costs. Conclusions: Patients who experience their care as more integrated may have higher expenditures on average. Thoughtful policy choices, further research, and innovations that enable patients to perceive integrated care at lower or neutral cost are needed.

► **Optimizing Physician Payment Models to Address Health System Priorities: Perspectives From Specialist Physicians**

KOFOWOROLA OGUNDEJI Y., QUINN A., LUNNEY M.,
et al.
2021

Healthcare Policy 17(1): 58-72.

<https://www.longwoods.com/content/26577/optimizing-physician-payment-models-to-address-health-system-priorities-perspectives-from-specialis>

Despite well-documented data on the mixed impact of physician payment models, there is limited evidence on

how to enhance existing payment model designs. This study examines the approaches to optimizing payment models from the perspective of specialist physicians to better support patient and physician experience and other health system objectives. Semi-structured interviews were conducted with 32 specialist physicians across Alberta, Canada. Data from the interviews were analyzed using a framework approach. Respondents emphasized the need to incentivize physicians with the right blend of financial and non-financial incentives, including physician wellness. Respondents also highlighted the need for physician involvement and accountability to optimize the value of physician payment models. Conclusion: To optimize physician payment models, it may be useful to include a blend of financial and non-financial incentives with clear accountability measures as this may better align physician practice with health system priorities.

► **Incentives For Physician Teams: Effectiveness of Performance Feedback and Payment Distribution Methods**

LIANG L.-L., TUSSING A. D., HUANG N., *et al.*
2021

Health Policy : Ahead of pub.

<https://doi.org/10.1016/j.healthpol.2021.07.007>

Best practices in team-based incentive design remain underexplored. This study examines under group-based pay-for-performance, how managers incentivize physicians for teamwork through internal feedback and payment distribution methods. In collaboration with Taiwan Association of Family Medicine, authors conducted a national survey of physician groups, with a response rate of 48.3%. Multilevel linear regression was applied to 134 groups, collectively consisting of 1,245 physicians in Taiwan. The outcome variables were two manager-rated scores for group performance on achieving (a) comprehensive, coordinated, continuous care, and (b) patient health improvement. The results indicate that providing each physician feedback on peer performance is superior to not providing it; when providing peer information within a group, concealing identities is superior to revealing them. These findings imply that application of the principle of social comparison can be effective; however, caution should be taken when disclosure of identifiable peer performance may intensify peer competition and undermine care coordination in team-based models. Further, groups that distribute payments equally among physicians perform better than groups that distributed pay-

ment proportionally to physicians' patient shares. The findings are germane to small teams, where physicians do not have full control over care processes and outcomes, and need to work cooperatively to maximize group-based payment.

► **Differences in Health Care Spending and Utilization Among Older Frail Adults in High-Income Countries: ICCONIC Hip Fracture Persona**

PAPANICOLAS I., FIGUEROA J. F., SCHOENFELD A. J., *et al.*
2021

Health Services Research : Ahead of pub.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13739>

The aim of this study is to explore differences in spending and utilization of health care services for an older person with frailty before and after a hip fracture. **Data Sources** We used individual-level patient data from five care settings. **Study Design** We compared utilization and spending of an older person aged older than 65 years for 365 days before and after a hip fracture across 11 countries and five domains of care as follows: acute hospital care, primary care, outpatient specialty care, post-acute rehabilitative care, and outpatient drugs. Utilization and spending were age and sex standardized. The data were compiled by the International Collaborative on Costs, Outcomes, and Needs in Care (ICCONIC) across 11 countries as follows: Australia, Canada, England, France, Germany, the Netherlands, New Zealand, Spain, Sweden, Switzerland, and the United States. **Principal Findings** The sample ranged from 1859 patients in Spain to 42,849 in France. Mean age ranged from 81.2 in Switzerland to 84.7 in Australia. The majority of patients across countries were female. Relative to other countries, the United States had the lowest inpatient length of stay (11.3), but the highest number of days were spent in post-acute care rehab (100.7) and, on average, had more visits to specialist providers (6.8 per year) than primary care providers (4.0 per year). Across almost all sectors, the United States spent more per person than other countries per unit (\$13,622 per hospitalization, \$233 per primary care visit, \$386 per MD specialist visit). Patients also had high expenditures in the year prior to the hip fracture, mostly concentrated in the inpatient setting. **Conclusion** Across 11 high-income countries, there is substantial variation in health care spending and utilization for an older person with frailty, both

before and after a hip fracture. The United States is the most expensive country due to high prices and above average utilization of post-acute rehab care.

► **Differences in Health Outcomes For High-Need High-Cost Patients Across High-Income Countries**

PAPANICOLAS I., RILEY K., ABIONA O., *et al.*
2021

Health Services Research : Ahead of pub.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13735>

The aim of this study is to explore variations in outcomes of care for two types of patient personas—an older frail person recovering from a hip fracture and a multimorbid older patient with congestive heart failure (CHF) and diabetes. We used individual-level patient data from 11 health systems. **Study Design** We compared inpatient mortality, mortality, and readmission rates at 30, 90, and 365 days. For the hip fracture persona, we also calculated time to surgery. **Outcomes** were standardized by age and sex. **Data Collection/Extraction Methods** Data was compiled by the International Collaborative on Costs, Outcomes and Needs in Care across 11 countries for the years 2016–2017 (or nearest): Australia, Canada, England, France, Germany, the Netherlands, New Zealand, Spain, Sweden, Switzerland, and the United States. **Principal Findings** The hip sample across ranged from 1859 patients in Aragon, Spain, to 42,849 in France. Mean age ranged from 81.2 in Switzerland to 84.7 in Australia, and the majority of hip patients across countries were female. The congestive heart failure (CHF) sample ranged from 742 patients in England to 21,803 in the United States. Mean age ranged from 77.2 in the United States to 80.3 in Sweden, and the majority of CHF patients were males. Average in-hospital mortality across countries was 4.1% for the hip persona and 6.3% for the CHF persona. At the year mark, the mean mortality across all countries was 25.3% for the hip persona and 32.7% for CHF persona. Across both patient types, England reported the highest mortality at 1 year followed by the United States. Readmission rates for all periods were higher for the CHF persona than the hip persona. At 30 days, the average readmission rate for the hip persona was 13.8% and 27.6% for the CHF persona. **Conclusion** Across 11 countries, there are meaningful differences in health system outcomes for two types of patients.

► **Lifetime Costs and Lifetime Net Public Expenditures of Smoking**

RASMUSSEN S. R., SØGAARD J. ET KJELLBERG J.
2021

European Journal of Public Health 31(3): 641-646.
<https://doi.org/10.1093/eurpub/ckaa209>

Current estimates of lifetime costs of smoking are largely based on model analyses using etiologic fractions for a variety of diseases or Markov chain models. Direct estimation studies based on individual data for health costs by smoking status over a lifetime are non-existent. We estimated lifetime costs in a societal perspective of 18-year-old daily-smokers (continuing smoking throughout adult life) and never-smokers in Denmark, as well as lifetime public expenditures in the two groups. Main outcomes were lifetime net public expenditures and lifetime health costs according to OECD definitions and lifetime earned incomes. Estimates of these outcomes were based on registries containing individual-level data. Confounder-adjusted differences between daily-smokers and never-smokers were interpreted as smoking-attributable lifetime public expenditures and costs. The net lifetime public expenditure is, on average, €20 520 higher for male 18-year-old daily-smokers than for never-smokers, but €9771 lower, for female daily-smokers compared with never-smokers. In male 18-year-old daily-smokers, average lifetime health costs are €9921 higher and average lifetime earned incomes are €91 159 lower than for never-smokers. The corresponding figures are €5849 higher and €23 928 lower, respectively, for women. 18-year-old male daily-smokers are net public spenders over their lifetime compared with never-smokers, while the opposite applies for women. In Denmark, smoking is associated with higher lifetime health costs for society and losses in earned incomes—both for men and women.

► **Evolution of Health Care Utilization and Expenditure During the Year Before Death in 2015 Among People with Cancer: French Snds-Based Cohort Study**

TANGUY-MELAC A., VERBOUX D., PESTEL L., *et al.*
2021

The European Journal of Health Economics 22(7): 1039-1052.
<https://doi.org/10.1007/s10198-021-01304-1>

Cancer patients have one of the highest health care expenditures (HCE) at the end of life. However, the

growth of HCE at the end of life remains poorly documented in the literature.

► **Exploratory Comparison of Healthcare Costs and Benefits of the UK's Covid-19 Response with Four European Countries**

THOM H., WALKER J., VICKERMAN P., *et al.*
2021

European Journal of Public Health 31(3): 619-624.
<https://doi.org/10.1093/eurpub/ckab019>

In responding to Covid-19, governments have tried to balance protecting health while minimizing gross domestic product (GDP) losses. We compare health-related net benefit (HRNB) and GDP losses associated with government responses of the UK, Ireland, Germany, Spain and Sweden from UK health-care payer perspective. We compared observed cases, hospitalizations and deaths under 'mitigation' to modelled events under 'no mitigation' to 20 July 2020. We thus calculated healthcare costs, quality adjusted life years (QALYs), and HRNB at £20,000/QALY saved by each country. On per population (i.e. per capita) basis, we compared HRNB with forecast reductions in 2020 GDP growth (overall or compared with Sweden as minimal mitigation country) and qualitatively and quantitatively described government responses. The UK saved 3.17 (0.32–3.65) million QALYs, £33 (8–38) billion healthcare costs and £1416 (220–1637) HRNB per capita at £20,000/QALY. Per capita, this is comparable to £1455 GDP loss using Sweden as comparator and offsets 46.1 (7.1–53.2)% of total £3075 GDP loss. Germany, Spain, and Sweden had greater HRNB per capita. These also offset a greater percentage of total GDP losses per capita. Ireland fared worst on both measures. Countries with more mask wearing, testing, and population susceptibility had better outcomes. Highest stringency responses did not appear to have best outcomes. Our exploratory analysis indicates the benefit of government Covid-19 responses may outweigh their economic costs. The extent that HRNB offset economic losses appears to relate to population characteristics, testing levels, and mask wearing, rather than response stringency.

Covid

► Covid-19: Not the Time For Health Economists? a Plea For More Proactive Health Economic Involvement

GRAF VON DEN SCHULENBURG J. M.
2021

The European Journal of Health Economics 22(7):
1001-1004.

<https://doi.org/10.1007/s10198-021-01349-2>

The Covid-19 pandemic does not seem to be the hour for economists. This is very astonishing as the COVID-19 pandemic has an enormous impact on all parts of the economy. Most sectors were hit hard by the direct consequences of the pandemic as well as by the meas-

ures to reduce infection rates. Governments jumped in with subsidies at record levels to stabilize economies by increasing national debt in very short time frames and at very significant levels. Looking at the current vaccination campaign, it is all the more astonishing that economists can only be found on the verge of decision-making. Why is that? Two answers are suggested in this editorial. First, economists have so far not yet developed standardized methods for evaluating vaccination. Second, the essence of any economic consideration is an estimate of costs. But precisely these cost estimates are extremely complex and difficult, as there is no transparency about the real costs and spending for the vaccination programs.

État de santé

Health Status

► A Short History of the Concept of Bias in Epidemiology

BRAULT N.
2021

Revue d'épidémiologie et de santé publique 69(4):
215-223.

Bias is a major methodological issue for epidemiology. However, only a few studies have been dedicated to the past and present formulations of the concept of bias. Moreover, the classical definition of bias as systematic deviation from the truth of results or inferences, definition which can be found in dictionaries of epidemiology, does not seem to either match the way epidemiologists use it in practice, or correspond to the different definitions given throughout its history. It is consequently important to elucidate this paradox. METHODS: In this historical and conceptual article, we study the different uses of the word «bias» in epidemiological literature, from classic articles in the 1950's about the link between smoking and lung cancer to the most recent epidemiology textbooks, the objective being to analyze the ways in which epidemiologists have defined, applied and modified this concept over time. We show that D.L. Sackett's article on bias in analytic research, published in 1979, put an

end, at least temporarily, to reflection in populational epidemiology that started thirty years before. More precisely, we show that Sackett's definition of bias corresponds more to the needs and goals of clinical epidemiology than to those of populational epidemiology. Concomitantly, populational epidemiologists such as K.J. Rothman redefined bias as a threat to the internal validity of a study, and epidemiological study as an «exercise in measurement of an effect rather than as a criterion-guided process for deciding whether an effect is present or not». It is thereby important to draw a distinction between two notions pertaining to bias: an epidemiological concept of bias, viewed as the lack of internal validity of an observational study; and a medical concept of bias, defined as deviation from the truth. The former concerns the design and methodology of epidemiological studies; the latter is more general and impels epidemiologists and physicians to be skeptical, and even critical, towards their own inferences.

► **Understanding the Life Experiences of People with Multiple Complex Needs: Peer Research in a Health Needs Assessment**

HARLAND J. M., ADAMS E. A., BOOBIS S., *et al.*
2021

European Journal of Public Health : Ahead of pub.
<https://doi.org/10.1093/eurpub/ckab142>

Multiple complex needs (MCN) describe a population experiencing a combination of homelessness, substance use, offending and/or mental ill-health. Using peer researchers, this study aimed to explore the perspectives of individuals with lived experience of MCN with regards to (i) issues leading to MCN and (ii) key intervention opportunities. As part of a health needs assessment in Gateshead (North East England), trained peer researchers interviewed 27 adults (aged ≥ 18 years) with experience of MCN, identified using purposive sampling methods. Peer researchers designed a topic guide for interviews which were audio recorded and thematically analyzed. Interviewees reported adverse childhood experiences leading to MCN including abuse, bereavement, parental imprisonment, family break-up and inadequate support. Mental ill-health, substance use, poverty, early experiences of unstable housing and acute homelessness were identified as major precedents for adulthood experiences of MCN. Between 16 and 20 years, access to housing, social and mental health support was perceived as having the potential to prevent circumstances worsening. Individuals perceived removing barriers to mental health, housing and welfare and financial supports could help. This study highlights the perceived role austerity, adverse childhood events and current service provision have in current and future experiences of MCN. Individuals expressed a need for future interventions and support to be judgement free and provided by workers who are educated about MCN and related adversity. Involving peer researchers and individuals with experience of MCN in future research and service provision could ensure appropriate measures and supports are put in place.

► **Dose–Response Association Between Adult Height and All-Cause Mortality: A Systematic Review and Meta-Analysis of Cohort Studies**

LI Q., LIU Y., SUN X., *et al.*
2020

European Journal of Public Health 31(3): 652-658.
<https://doi.org/10.1093/eurpub/ckaa213>

We conducted a systematic review and meta-analysis from published cohort studies to examine the association of adult height and all-cause mortality and to further explore the dose–response association. PubMed, The Cochrane Library, The Ovid, CNKI, CQVIP and Wanfang databases were searched for articles published from database inception to 6 February 2018. We used the DerSimonian–Laird random-effects model to estimate the quantitative association between adult height and all-cause mortality and the restricted cubic splines to model the dose–response association. We included 15 articles, with 1 533 438 death events and 2 854 543 study participants. For each 5-cm height increase below the average, the risk of all-cause mortality was reduced by 7% [relative risk (RR) = 0.93, 95% confidence interval (CI), 0.89–0.97] for men and 5% (RR = 0.95, 95% CI, 0.90–0.99) for women. All-cause mortality had a U-shaped association with adult height, the lowest risk occurring at 174 cm for men and 158 cm for women (both $P_{\text{nonlinearity}} < 0.001$). Relative to the shortest adult height (147 cm for men and 137 cm for women), men at 174 cm had a 47% lower likelihood of all-cause mortality and women at 158 cm a 33% lower risk of all-cause mortality. Our study suggests that the relation between adult height and all-cause mortality is approximately U-shaped in both men and women.

► **Estimation of Cancers Caused By Light to Moderate Alcohol Consumption in the European Union**

ROVIRA P. ET REHM J.
2020

European Journal of Public Health 31(3): 591-596.
<https://doi.org/10.1093/eurpub/ckaa236>

Research has identified alcohol to be an important risk factor for several types of cancers. This study estimates the number of incident cancers attributable to alcohol consumption in the European Union (EU) in 2017, with a special focus on those caused by light to moderate drinking levels. The attributable-fraction methodology is used to estimate the number of new cancer cases in

the year 2017 in the EU caused by alcohol use, and further examines those due to light to moderate drinking levels, defined here as alcohol consumption of ≤ 20 g of pure alcohol per day. Light to moderate drinking levels of alcohol caused almost 23 000 new cancer cases in the EU in 2017, and accounted for 13.3% of all alcohol-attributable cancers, and 2.3% of all cases of the seven alcohol-related cancer types. Almost half of these (~11,000 cases) were female breast cancers. Also, more than a third of the cancer cases due to light to moderate drinking resulted from a light drinking level

of <math>< 1</math> standard drink per day (total: 37%; women: 40%; men: 32%). Alcohol use, including light to moderate drinking, continues to cause considerable cancer burden, and efforts should be made to reduce this burden. In addition to the alcohol control policies suggested by the World Health Organization, public information campaigns and the placement of warning labels on alcohol containers advising of the cancer risk associated with alcohol use should be initiated to increase knowledge about the alcohol-cancer link.

Covid

► **Epidemiology and Control of SARS-Cov-2 Epidemics in Partially Vaccinated Populations: A Modeling Study Applied to France.**

BOSETTI P., TRAN KIEM C., ANDRONICO A., *et al.*
2021

Hal.

<https://hal-pasteur.archives-ouvertes.fr/pasteur-03272638>

SARS-CoV-2 epidemics are expected to change with vaccination. Here, we used an age stratified compartmental model applied to France to anticipate how partial vaccination may modify SARS-CoV-2 epidemiology and determine implications for epidemic control this autumn. In our baseline scenario characterized by $R_0 = 4$ and a vaccine coverage of 30%-70%-90% among 12-17, 18-59 and ≥ 60 y.o., important stress on healthcare is expected in the absence of measures. Unvaccinated individuals contribute 12 times more to transmission than vaccinated ones. Unvaccinated adults ≥ 60 y.o. represent 3% of the population but 36% of hospitalisations. Non-pharmaceutical measures have a similar impact whether they apply to all or only to unvaccinated individuals. Intensity of measures required to control an epidemic rebound remain substantially lower than in the absence of vaccines. Of all the interventions considered including repeated testing and non-pharmaceutical measures, vaccination of the unvaccinated is the most effective. Vaccinating children is important to protect them from the deleterious effects of non-pharmaceutical measures. Strategies to control an autumn wave should account for the changing epidemiology of SARS-CoV-2 in partially vaccinated populations.

► **Quelles évolutions des décès durant la pandémie de Covid-19 ? Exemples pour les pensionnés de la CNRACL, de l'Ircantec, du FSPOEIE et de la retraite des Mines**

BROSSIER A., JULLIARD S. ET MARTEAU M.
2021

Questions Politiques Sociales : Les Brèves(8)

<https://politiques-sociales.caissesdesdepots.fr/qps-les-breves-ndeg8>

Cette étude propose un premier constat sur l'évolution des décès observés durant la pandémie de Covid-19 parmi les pensionnés de quatre régimes de retraite gérés par la Caisse des dépôts : la CNRACL, l'Ircantec, la FSPOEIE et la retraite des Mines. Il met en avant les augmentations constatées en 2020 par rapport aux années précédentes et les populations les plus touchées en fonction de l'âge, du genre et de la situation géographique.

► **Diabetes Increases Severe COVID-19 Outcomes Primarily in Younger Adults**

DIEDISHEIM M., DANCOISNE E., GAUTIER J.-F., *et al.*
2021

The Journal of Clinical Endocrinology & Metabolism : 106(9) : e3364–e3368

<https://doi.org/10.1210/clinem/dgab393>

Diabetes is reported as a risk factor for severe coronavirus disease 2019 (COVID-19), but whether this risk is similar in all categories of age remains unclear. To investigate the risk of severe COVID-19 outcomes in hospitalized patients with and without diabetes according to age categories. We conducted a retrospective observational cohort study of 6314 consecutive patients

hospitalized for COVID-19 between February and 30 June 2020 in the Paris metropolitan area, France; follow-up was recorded until 30 September 2020. The main outcome was a composite outcome of mortality and orotracheal intubation in subjects with diabetes compared with subjects without diabetes, after adjustment for confounding variables and according to age categories. Diabetes was recorded in 39 % of subjects. Main outcome was higher in patients with diabetes, independently of confounding variables (hazard ratio [HR] 1.13 [1.03-1.24]) and increased with age in individuals without diabetes, from 23 % for those <50 to 35 % for those >80 years but reached a plateau after 70 years in those with diabetes. In direct comparison between patients with and without diabetes, diabetes-associated risk was inversely proportional to age, highest in <50 years and similar after 70 years. Similarly, mortality was higher in patients with diabetes (26 %) than in those without diabetes (22 %, $P < 0.001$), but adjusted HR for diabetes was significant only in patients younger than age 50 years (HR 1.81 [1.14-2.87]). Diabetes should be considered as an independent risk factor for the severity of COVID-19 in young adults more so than in older adults, especially for individuals younger than 70 years. Voir l'analyse en français sur le site de l'AP-HP : <https://www.aphp.fr/actualite/le-diabete-augmente-le-risque-de-forme-severe-du-covid-19-principalement-chez-les-jeunes>

► **Différences de mortalité par Covid-19 : conséquence des imperfections et de la diversité des systèmes de collecte des données**

GARCIA J., TORRES C., BARBIERI M., *et al.*
2021

Population 76(1): 37-76.

<https://www.cairn.info/revue-population-2021-1-page-37.htm>

L'urgence que représente la compréhension de la pandémie de Covid-19 a entraîné des différences considérables entre les procédures de collecte des données des pays concernés, qui s'efforcent tous de produire des informations en temps réel mais qui restent des statistiques de mortalité imparfaites. Pour remédier à ce problème, l'analyse porte sur les décomptes de décès par Covid-19 provenant de la base de données « La démographie des décès par Covid-19 » (<https://dc-covid.site.ined.fr/fr/>) ainsi que leurs limites. Cet article souligne des aspects importants touchant aux données qui limitent la possibilité de mener des comparaisons internationales. Pour pallier ces difficultés,

les sources sont classées en fonction du caractère exhaustif de leurs données, puis les décomptes de décès sont analysés et comparés pour 16 pays. Bien comprendre les caractéristiques de la collecte des données est fondamental pour le traitement des statistiques imparfaites.

► **Estimated Mortality Increases During the COVID-19 Pandemic By Socioeconomic Status, Race, and Ethnicity**

MILLER S., WHERRY L. R. ET MAZUMDER B.
2021

Health Affairs: 40(8). 1252-1260

<https://doi.org/10.1377/hlthaff.2021.00414>

This article estimates changes in all-cause mortality due to the COVID-19 pandemic by socioeconomic characteristics and occupation for nonelderly adults in the US, using large-scale, national survey data linked to administrative mortality records. Mortality increases were largest for adults living in correctional facilities or in health care related group quarters, those without health insurance coverage, those with family incomes below the federal poverty level, and those in occupations with limited work-from-home options. For almost all subgroups, mortality increases were higher among non-Hispanic Black respondents than among non-Hispanic White respondents. Hispanic respondents with health insurance, those not living in group quarters, those with work-from-home options, and those in essential industries also experienced larger increases in mortality during the COVID-19 crisis compared with non-Hispanic Whites in those categories. Occupations that experienced the largest mortality increases were related to installation, maintenance, and repair and production. This research highlights the relevance of individual economic, social, and demographic characteristics during the COVID-19 crisis.

► **Assessing Excess Mortality in Times of Pandemics Based on Principal Component Analysis of Weekly Mortality Data—The Case of Covid-19**

VANELLA P., BASELLINI U. ET LANGE B.
2021

Genus 77(1): 16.

<https://doi.org/10.1186/s41118-021-00123-9>

The Covid-19 outbreak has called for renewed attention to the need for sound statistical analyses to mon-

itor mortality patterns and trends over time. Excess mortality has been suggested as the most appropriate indicator to measure the overall burden of the pandemic in terms of mortality. As such, excess mortality has received considerable interest since the outbreak of COVID-19 began.

► **Disease-Specific Excess Mortality During the COVID-19 Pandemic: An Analysis of Weekly US Death Data For 2020**

ZHU D., OZAKI A. ET VIRANI S.
2021

American Journal of Public Health: e1-e5.
<https://doi.org/10.2105/AJPH.2021.306315>

The objectives of this paper are to examine the disease-specific excess deaths during the COVID-19 pandemic in the United States. Methods. We used

weekly death data from the National Center for Health Statistics to analyze the trajectories of excess deaths from specific diseases in the United States during the Covid-19 pandemic, at the national level and in 4 states, from the first to 52nd week of 2020. We used the average weekly number of deaths in the previous 6 years (2014-2019) as baseline. Results. Compared with the same week at baseline, the trajectory of number of excess deaths from cardiovascular disease (CVD) was highly parallel to the trajectory of the number of excess deaths related to Covid-19. The number of excess deaths from diabetes mellitus, influenza and respiratory diseases, and malignant neoplasms remained relatively stable over time. Conclusions. The parallel trajectory of excess mortality from CVD and Covid-19 over time reflects the fact that essential health services for noncommunicable diseases were reduced or disrupted during the Covid-19 pandemic, and the severer the pandemic, the heavier the impact.

Géographie de la santé

Geography of health

► **Vers un investissement territorial de santé**

AMRI K.
2021

Gestions Hospitalières(606): 262-267.

Le Comité interministériel de la performance et de la modernisation de l'offre de soins hospitaliers (Copermo) a été supprimé suite au Ségur de la santé. Les nombreuses critiques concernant la lourdeur et les attendus liés à son fonctionnement ont eu en effet gain de cause sur l'existence de cette instance. La récente circulaire du 10 mars 2021 relative à la relance de l'investissement dans le système de santé, dans le cadre du Ségur de la santé et de France relance, vise ainsi à proposer une nouvelle politique d'investissement qui sera mise en œuvre en rupture avec les modalités retenues depuis dix ans notamment dans le cadre du Coperno. Ce dispositif s'entend s'appuyer sur une nouvelle gouvernance à trois étapes, avec la mise en place d'un conseil scientifique, d'un Conseil national d'investissement en santé (Cnis) et d'un comité de pilotage (Copilo).

► **Regional Medical Practice Variation in High-Cost Healthcare Services**

BERGER M. ET CZYPIONKA T.
2021

The European Journal of Health Economics 22(6): 917-929.

<https://doi.org/10.1007/s10198-021-01298-w>

Magnetic resonance imaging (MRI) is a popular yet cost-intensive diagnostic measure whose strengths compared to other medical imaging technologies have led to increased application. But the benefits of aggressive testing are doubtful. The comparatively high MRI usage in Austria in combination with substantial regional variation has hence become a concern for its policy makers. We use a set of routine healthcare data on outpatient MRI service consumption of Austrian patients between Q3-2015 and Q2-2016 on the district level to investigate the extent of medical practice variation in a two-step statistical analysis combining multivariate regression models and Blinder–Oaxaca decomposition. District-level MRI exam rates per 1.000 inhabitants range from 52.38 to 128.69. Controlling for a set of regional characteristics in a multivariate

regression model, we identify payer autonomy in regulating access to MRI scans as the biggest contributor to regional variation. Nevertheless, the statistical decomposition highlights that more than 70% of the regional variation remains unexplained by differences between the observable district characteristics. In the absence of epidemiological explanations, the substantial regional medical practice variation calls the efficiency of resource deployment into question.

► **Intérêts et limites d'une approche cartographique et géographique pour le management des parcours de soins en santé : l'exemple de l'Auvergne**

CHAZE M., LANGLOIS É., MÉRIADE L., *et al.*
2021

Revue d'Économie Régionale & Urbaine Juin(3): 397-420.

<https://www.cairn.info/revue-d-economie-regionale-et-urbaine-2021-3-page-397.htm>

Les notions de « parcours patient », « parcours de soins », « parcours de santé », « parcours de vie » sont aujourd'hui largement mobilisées et reprises dans les discours et discussions politiques et professionnels autour de l'amélioration de la prise en charge des patients (Porter, 2010). Dans le domaine managérial, la mobilisation de ces notions souffre d'une importante faiblesse conceptuelle. Peu de réflexions empiriques ou scientifiques permettent de définir précisément comment construire le management intégré et global d'un parcours de soins dans et hors les murs des établissements de santé. L'approche de cartographie géographique peut s'avérer très pertinente pour penser un management des parcours territorialisés en représentant conjointement les ressources médicales et soignantes et les populations de patients. L'application de cette approche à l'Auvergne permet de définir trois types de territoires de santé et de repérer des leviers d'action pour un management intégré des parcours de soins.

► **Géographie d'un changement social. La diffusion spatiale des naissances hors mariage en France depuis un demi-siècle**

DOIGNON Y.
2020

L'Espace géographique 49(3): 213-232.

<https://www.cairn.info/revue-espace-geographique-2020-3-page-213.htm>

À partir d'une grande base de données provenant des registres de l'état civil, nous étudions les dynamiques spatiales des naissances hors mariage en France sur une période de temps importante (entre 1968 et 2017, soit près d'un demi-siècle) et à un niveau géographique fin (pseudo-cantons). Les résultats mettent en évidence une diffusion spatiale de la natalité hors mariage, mais aussi le rôle important des structures socio-culturelles traditionnelles qui s'efface progressivement pour faire émerger une nouvelle structure spatiale. Enfin, une inversion de la hiérarchie urbaine se déroule à la fin des années 1980, avec une natalité hors mariage plus forte dans les petites villes que les grandes villes.

► **Comparison of Rural and Urban French GPs' Activity: A Cross-Sectional Study**

LURQUIN B., KELLOU N., COLIN C., *et al.*
2021

Rural Remote Health 21(3): 5865.

<https://pubmed.ncbi.nlm.nih.gov/34469693/>

In various countries, a shortage of general practitioners (GPs) and worrying health statistics on risk factors, morbidity and mortality have been observed in rural areas. However, few comparative data are available on GP activities according to their location. The aim of this study was to analyse French GP activities according to their rural or urban practice location. This study was ancillary to the Ecogen study, which was a cross-sectional, multicentre, national study conducted in 128 French general practices in 2012. The database included 20 613 consultations. The mean yearly number of consultations per GP was higher in rural areas ($p < 0.0001$), with a shorter consultation length ($p < 0.0001$). No difference was found for GP sex ($p = 0.41$), age ($p = 0.87$), type of fees agreement ($p = 0.43$), and type of practice ($p = 0.19$) according to their practice location. Urban patients were younger, and there was a lower percentage of patients over 75 years ($p < 0.001$). GPs more frequently consulted at patients' homes in rural areas ($p < 0.0001$). The mean

number of chronic conditions managed was higher in rural areas and urban clusters than in urban areas ($p < 0.0001$). Hypertension ($p < 0.0001$), type 2 diabetes ($p = 0.003$), and acute bronchitis/bronchiolitis ($p = 0.01$) were more frequently managed in rural areas than in urban clusters and areas. Health maintenance/prevention ($p < 0.0001$) and no disease situations ($p < 0.0001$) were less frequent in rural areas. Drug prescription was more frequent in rural areas than in urban clusters and areas ($p < 0.0001$). French rural GPs tend to have a higher workload than urban GPs. Rural patients have more chronic conditions to be managed but are offered fewer preventive services during consultations. It is necessary to increase the GP workforce and develop cooperation with allied health professionals in rural areas.

► **Penser les inégalités de santé ville/campagne à partir des territoires**

VIGNERON E.
2021

Gestions Hospitalières(606): 302-309.

<http://gestions-hospitalieres.fr/penser-les-inegalites-de-sante-ville-campagne-a-partir-des-territoires/>

Les inégalités territoriales de santé sont une priorité constamment affirmée des politiques de santé mais, en France, elles ne parviennent pas à se résorber malgré de nombreux dispositifs prévus depuis longtemps. Elles s'aggravent dans la période récente. Emmanuel Vigneron les mesure ici par type de territoire, ce qui permet de contextualiser la consommation de soins hospitaliers à partir du lieu de résidence des patients. Le PMSI ne contient en effet aucune donnée socio-économique sur les patients autre que celle de contexte géographique.

Covid

► **Le regard de géographes de la santé sur la pandémie**

NUGUES M. ET CASCALES J.
2021

Gestions hospitalières(607): 333-338.

Cet article revient sur la propagation de la Covid-19 en France et dans le monde sous un angle géographique.

► **La sécurité sanitaire au village. La crise du Covid-19 vue d'en bas**

MICHEL L. ET SCHWEYER F.-X.
2021

Revue française des affaires sociales(2): 13-35.

<https://www.cairn.info/revue-francaise-des-affaires-sociales-2021-2-page-13.htm>

Cet article vise à comprendre comment la gestion de la crise a été organisée et vécue sur un territoire rural du Grand-Est situé en zone rouge. À partir d'une enquête conduite dès le début de l'épidémie (mars 2020) et jusqu'en juillet 2020, l'analyse porte sur la réception des mesures de sécurité sanitaire, sur la mobilisation locale entre entraide, peurs et tensions et, enfin, sur l'action de professionnels de santé regroupés au sein d'une structure d'exercice coordonné. L'enquête montre que la légitimité des mesures de sécurité sani-

taire n'a pas été discutée mais que les modalités de leur application ont été critiquées au plan organisationnel et moral. La crise a en effet montré combien les démarches de soins primaires dans cet environnement rural étaient ancrées dans un entrecroisement de liens sociaux mis à l'épreuve par une réponse sécuritaire perçue comme stressante et parfois désajustée. Le pôle de santé existant sur le territoire a été un espace de soutien et d'échange pour les professionnels de santé, mais aussi un vecteur ayant facilité la réception des messages des autorités. Les formes de solidarité déployées ont mis au jour une sorte de déssectorisation de la santé.

Disability

► Participation of People Living with Disabilities in Physical Activity: A Global Perspective

MARTIN GINIS K. A., VAN DER PLOEG H. P., FOSTER C., *et al.*

2021

The Lancet : 398(10298) : 443-455

[https://doi.org/10.1016/S0140-6736\(21\)01164-8](https://doi.org/10.1016/S0140-6736(21)01164-8)

Approximately 1.5 billion people worldwide live with a physical, mental, sensory, or intellectual disability, about 80% of which are in low-income and middle-income countries. This Series paper provides a global overview of the prevalence, benefits, and promotion policies for physical activity for people living with disabilities (PLWD). PLWD are 16–62% less likely to meet physical activity guidelines and are at higher risk of serious health problems related to inactivity than people without disabilities. Meta-analyses have shown that

physical activity has beneficial effects on cardiovascular fitness (average standardised mean difference [SMD] 0.69 [95% CI 0.31–1.01]), musculoskeletal fitness (0.59 [0.31–0.87]), cardiometabolic risk factors (0.39 [0.04–0.75]), and brain and mental health outcomes (0.47 [0.21–0.73]). These meta-analyses also show that health benefits can be achieved even with less than 150 min of physical activity per week, and suggest that some physical activity is better than none. Meta-analyses of interventions to increase physical activity for PLWD have reported effect sizes ranging from SMD 0.29 (95% CI 0.17–0.41, $k=10$) to 1.00 (0.46–1.53, $k=10$). There is increasing awareness among policy makers of the needs of PLWD for full participation in physical activity. Physical activity action plans worldwide must be adequately resourced, monitored, and enforced to truly advance the fundamental rights of PLWD to fully participate in physical activity.

Hospital

► The Impact of Urgent Care Centers on Nonemergent Emergency Department Visits

ALLEN L., CUMMINGS J. R. ET HOCKENBERRY J. M.
2021

Health Services Research 56(4): 721-730.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13631>

The aim of this study is to estimate the impact of urgent care centers on emergency department (ED) use. Data Sources Secondary data from a novel urgent care center database, linked to the Healthcare Cost and Utilization Project State Emergency Department Databases (SEDD) from six states. Study Design We used a difference-in-differences design to examine ZIP code-level changes in the acuity mix of emergency department visits when local urgent care centers were open versus closed. ZIP codes with no urgent care centers

served as a control group. We tested for differential impacts of urgent care centers according to ED wait time and patient insurance status. Data Collection/Extraction Methods Urgent care center daily operating times were determined via the urgent care center database. Emergency department visit acuity was assessed by applying the NYU ED algorithm to the SEDD data. Urgent care locations and nearby emergency department encounters were linked via zip code. Principal Findings We found that having an open urgent care center in a ZIP code reduced the total number of ED visits by residents in that ZIP code by 17.2% ($P < 0.05$), due largely to decreases in visits for less emergent conditions. This effect was concentrated among visits to EDs with the longest wait times. We found that urgent care centers reduced the total number of uninsured and Medicaid visits to the ED by 21% ($P < 0.05$) and 29.1% ($P < 0.05$), respectively. Conclusions During the hours they are open, urgent care centers appear to be

treating patients who otherwise would have visited the ED. This suggests that urgent care centers have the potential to reduce health care expenditures, though questions remain about their net cost impact. Future work should assess whether urgent care centers can improve health care access among populations that often experience barriers to receiving timely care.

► **L'hôpital sous contrôle : dossier**

BAGUET F., CHOUVEL R., BUDET J. M., *et al.*
2021

Gestions Hospitalières(607): 350-373.

Contrôler, certifier, inspecter, accréditer : autant de termes qui sont rentrés dans le vocabulaire quotidien des établissements de santé, avec souvent des difficultés pour comprendre les différences de définition ou les acteurs qui en ont la charge. Plus inquiétant, les professionnels de santé ont souvent le sentiment de voir s'accumuler les audits et les évaluations, sans parvenir à en déterminer les impacts concrets pour la prise en charge des patients ou pour l'organisation quotidienne de leur travail. Cet article fait un tour d'horizon de la question.

► **How Have Casemix, Cost and Hospital Stay of Inpatients in the Last Year of Life Changed over the Past Decade? Evidence From Italy**

BERTA P., LOVAGLIO P. G. ET VERZILLO S.
2021

Health Policy 125(8): 1031-1039.

<https://doi.org/10.1016/j.healthpol.2021.06.005>

Healthcare utilisation and expenditure are highly concentrated in hospital inpatient services, in particular in end-of-life care with the peak occurring in the very last year of life, regardless of patient age. Few scientific studies have investigated hospital costs and stays of patients at the end of life, and even fewer studies have analysed their evolution over time. In this paper, we exploit hospitalisation data for the Lombardy region of Italy with the aim of studying the evolution of hospital casemix, costs and stays of chronic patients, and compare the last year of life of two cohorts of patients who died in 2005 and 2014. Despite an overall three-year increase in the age at death, the results showed a significant decrease in hospital costs and use due to reduced interventions and length of hospital stays. However, this was not associated with an

increase in quality of life/conditions (as indicated by clinical casemix as a proxy) for end-of-life patients; patients' casemix characteristics and clinical condition, as measured by the number of comorbidities, disease severity, prevalence of pulmonary disease and heart failure diagnosis, significantly worsened over the decade. This gives rise to important health policy concerns on how to identify effective policies and possible changes in healthcare system organisation to move from hospital-centred care to a community-centred approach whose value has been demonstrated during the COVID-19 pandemic.

► **T2A, fin de partie ?**

BRUNET J.
2021

Gestions Hospitalières(606): 268-273.

Dans une interview accordée à Libération le 11 décembre 2017, Agnès Buzyn, alors ministre de la Santé, déclare que la « tarification à l'activité (T2A) nous a fait perdre le sens de la mission de l'hôpital en nous faisant courir après la rentabilité, et que cette logique était arrivée à son terme ». En 2020, en pleine crise épidémique de coronavirus, le président de la République déclare à son tour que « la santé gratuite sans conditions [...], ce ne sont pas des coûts ou des charges, mais des biens précieux, des atouts indispensables quand le destin frappe [...]. Il est des biens et des services qui doivent être placés en dehors des lois du marché ». Des discours qui vont à rebours de la politique d'austérité menée tambour battant à l'endroit des hôpitaux depuis vingt ans. Mais au-delà des discours politiques, qu'en est-il réellement de l'avenir du principal mode de financement des hôpitaux : la tarification à l'activité.

► **Hospital Performance in the First 6 Years of Medicare's Value-Based Purchasing Program**

CARROLL N. W. ET CLEMENT J. P.
2021

Medical Care Research and Review 78(5): 598-606.

<https://journals.sagepub.com/doi/abs/10.1177/1077558720927586>

The Medicare value-based purchasing (VBP) program, ongoing since 2013, uses financial bonuses and penalties to incentivize hospital quality improvements. Previous research has identified characteristics of

penalized hospitals, but has not examined characteristics of hospitals with improvements in VBP program performance or consistent good performance. We identify five different trajectories of program performance (improvement, decline, consistent good or poor performance, mixed). A total of 11% of hospitals were penalized every year of the program, 24% improved their VBP program performance, 14% of hospitals consistently earned a bonus, while 18% performed well in the program's early years but experienced declines in performance. In 2013, organizational and community characteristics were associated with higher odds of improving relative to performing poorly every year. Few variables under managers' control were associated with program improvement, though accountable care organization participation was in some models. We find changes in VBP program metrics may have contributed to improvement in some hospitals' program scores.

► **Care Continuity and Care Coordination: A Preliminary Examination of Their Effects on Hospitalization**

CHEN C.-C. ET CHENG S.-H.
2021

Medical Care Research and Review 78(5): 475-489.

<https://journals.sagepub.com/doi/abs/10.1177/1077558720903882>

Both care continuity and care coordination are important features of the health care system. However, little is known about the relationship between care continuity and care coordination, their effects on hospitalizations, and whether these effects vary across patients with various levels of comorbidity. This study employed a panel study design with a 3-year follow-up from 2007 to 2011 in Taiwan's universal health coverage system. Patients aged 18 years or older who were newly diagnosed with diabetes in 2007 were included in the study. We found that the correlation between care continuity and care coordination was low. Patients with higher levels of care continuity or care coordination were less likely to experience hospitalization for diabetes-related conditions. Furthermore, both care continuity and care coordination showed stronger effects for patients with higher comorbidity scores. Improving care continuity and coordination for patients with multiple chronic conditions is the right direction for policymakers.

► **Using Fees to Reduce Bed-Blocking: A Game Between Hospitals and Long-Term Care Providers**

KVERNDOKK S. ET MELBERG H. O.
2021

The European Journal of Health Economics 22(6): 931-949.

<https://doi.org/10.1007/s10198-021-01299-9>

In several countries, a fee has been introduced to reduce bed-blocking in hospitals. This paper studies the implications of this fee for the strategic decisions of the hospitals and the long-term care providers. We introduce a Stackelberg game where the hospital is the leader and the care provider the follower. The policy reduces the treatment time at the hospital but does not necessarily lead to less bed-blocking, as this depends on the treatment time and bed-blocking before the reform. We test the results with data from the Norwegian Coordination Reform introduced in 2012 and find that this reform led to a large reduction in bed-blocking. The direct effect was even larger than a naïve comparison would suggest because hospitals began to report patients as ready to be discharged earlier than before the reform. Confronted with the theoretical predictions, this would mean that hospital services in average were set relatively close to the minimum levels before the reform.

► **Common Patterns in the Public Reporting of Waiting Time and Waiting List Information: Findings From a Sample of OECD Jurisdictions**

LEE M., MARTIN-CARROLL M., VON MOLLENDORFF W., *et al.*
2021

Health Policy 125(8): 1002-1012.

<https://doi.org/10.1016/j.healthpol.2021.05.013>

We present findings from a review of published literature and administrative documentation on waiting time and waiting list reporting models for elective treatment in a sample of international jurisdictions (a subset of OECD countries, with regional reporting regimes treated as distinct jurisdictions). In this paper we identified common patterns in the measurement and reporting of waiting time and waiting list information for elective treatment. We mapped the waiting time, waiting list, and key performance indicator statistics reported by 15 English-speaking international jurisdictions. Three distinct patterns of maximum wait-

ing time target measures for elective treatment were identified amongst our international sample following our patient pathway event time-point analysis: (i) full-pathway maximum wait time targets; (ii) separate wait time targets for “time-to-diagnosis” and “time-to-treatment”; and (iii) “Time-to-Treatment” waiting time target only. Our review also revealed common patterns in the reporting of waiting time and waiting list statistics as well as KPI measures amongst a sub-sample of English-speaking jurisdictions. These common patterns provide a starting point towards more standardised measurement and reporting of waiting time and waiting list statistics in benchmarking access to elective care internationally.

► **Ambulatory Care—Sensitive Condition Hospitalizations Among Medicare Beneficiaries**

LIN Y.-H., EBERTH J. M. ET PROBST J. C.
2016

American Journal of Preventive Medicine 51(4): 493-501.

<https://doi.org/10.1016/j.amepre.2016.05.005>

This study examined the association between the distribution of primary care physicians and Medicare beneficiaries’ ambulatory care sensitive condition hospitalizations using both statistical and spatial analyses. Methods Data from the 2014 County Health Rankings, 2013–2014 Area Resource File, and the 2014 Food Environment Atlas Data File were integrated to perform county-level ordinary least squares and geographically weighted regression. Analyses were conducted in late 2015. Results Primary care physician density was found to be negatively associated with Medicare beneficiaries’ ambulatory care sensitive condition hospitalization rate in both ordinary least squares ($\beta = -5.88$, $p = 0.0037$) and geographically weighted regression models (37.08% of all counties), with the latter model finding significant relationships in the South and Northeast. Conclusions Preventable hospitalizations are high in areas of the U.S. that have low primary care physician density and other health-care resources, large non-white populations, high levels of area deprivation, and rural designations. Using geospatial techniques helped document areas of greatest concern for potential intervention. Future research needs to account for these regional differences and target surveillance accordingly.

► **Hospitalization For Ambulatory Care Sensitive Conditions: What Conditions Make Inter-Country Comparisons Possible?**

ROCHA J. V. M., SANTANA R. ET TELLO J. E.
2021

Health Policy OPEN 2: 100030.

<https://doi.org/10.1016/j.hpopen.2021.100030>

Hospitalizations for ambulatory care sensitive conditions have been extensively used in health services research to assess access, quality and performance of primary health care. Inter-country comparisons can assist policy-makers in pursuing better health outcomes by contrasting policy design, implementation and evaluation. The objective of this study is to identify the conceptual, methodological, contextual and policy dimensions and factors that need to be accounted for when comparing these types of hospitalizations across countries. A conceptual framework for inter-country comparisons was drawn based on a review of 18 studies with inter-country comparison of ambulatory care sensitive conditions hospitalizations. The dimensions include methodological choices; population’s demographic, epidemiologic and socio-economic profiles and features of the health services and system. Main factors include access and quality of primary health care, availability of health workforce and health facilities, health interventions and inequalities. The proposed framework can assist in designing studies and interpreting findings of inter-country comparisons of ambulatory care sensitive conditions hospitalizations, accelerating learning and progress towards universal health coverage.

► **Stability over Time of the “Hospital Effect” on 30-Day Unplanned Readmissions: Evidence From Administrative Data**

ROSHANGHALB A., MAZZALI C., LETTIERI E., *et al.*
2021

Health Policy : Ahead of pub.

<https://doi.org/10.1016/j.healthpol.2021.07.009>

Past studies showed that hospital characteristics affect hospital performance in terms of 30-day unplanned readmissions, proving the existence of a “hospital effect”. However, the stability over time of this effect has been under-investigated. This study offers new evidence about the stability over time of the hospital effect on 30-day unplanned readmissions. Using 78,907 heart failure (HF) records collected from 116 hospi-

tals in the Lombardy Region (Northern Italy) over three years (2010-2012), this study analysed hospital performance in terms of 30-day unplanned readmissions. Hospitals with unusually high and low readmission rates were identified through multi-level regression that combined both patient and hospital covariates in

each year. Our results confirm that although hospital covariates – and the connected managerial choices – affect the 30-day unplanned readmissions of a specific year, their effect is not stable in the short-term (3 years). This has important implications for pay-for-performance schemes and quality improvement initiatives.

Covid

► **Reduction of the Emergency Activity, During the Covid 19 Italian Lockdown, What's the Lesson to Learn?**

INAMA M., CASARIL A., ALBERTI L., *et al.*
2021

Health Policy : 125(9) : 1173-1178

<https://doi.org/10.1016/j.healthpol.2021.07.013>

The Covid 19 pandemic was declared on the 9th of March 2020. The health crisis affected the whole world with a very high and unexpected number of infected people. The situation forced the declaration of lockdown and a worldwide health system reorganization. Surprisingly, the social distancing laws caused a reduction of urgent hospital activities not Covid 19 related. The aim of this manuscript is to analyze the reasons why fewer emergencies were described during the 2020 Italian lockdown. The Data reporting urgent Emergency Room (ER) activity, during the first three weeks of the Italian lockdown (Group 1), were analyzed and compared with the same period in 2019 (Group 2). During the study period in 2020, there was a 46,5% reduction in ER activity compared to that in 2019. Nevertheless, the hospitalization rate was higher in the 2020 then in 2019 ($p < 0.05$). The present data showed that almost half of the basic ER activity araised from mild health problems that could be followed by territorial health services. The strengthening of territorial medical services would allow hospitals to handle critical situations more easily and to focus activity by reducing the waiting list.

► **Hospitalization For Self-Harm During the Early Months of the COVID-19 Pandemic in France: A Nationwide Retrospective Observational Cohort Study**

JOLLANT F., ROUSSOT A., CORRUBLE E., *et al.*
2021

The Lancet Regional Health – Europe 6.

<https://doi.org/10.1016/j.lanepe.2021.100102>

Little is known to date about the impact of Covid-19 pandemic on self-harm. The number of hospitalizations for self-harm (ICD-10 codes X60-X84) in France from 1st January to 31st August 2020 (including a two-month confinement) was compared to the same periods in 2017–2019. Statistical methods comprised Poisson regression, Cox regression and Student's *t*-test, plus Spearman's correlation test relating to spatial analysis of hospitalizations.

Health Inequalities

► **Did Medicaid Slow Declines in Access to Health Care During the Great Recession?**

BENITEZ J. A., PEREZ V. E. ET CHEN J.
2021

Health Services Research 56(4): 655-667.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13645>

The aim of this study is to examine whether broadened access to Medicaid helped insulate households from declines in health coverage and health care access linked to the 2007-2009 Great Recession. Data Source 2004-2010 Behavioral Risk Factor Surveillance System (BRFSS). Study Design Flexible difference-in-difference regressions were used to compare the impact of county-level unemployment on health care access in states with generous Medicaid eligibility guidelines versus states with restrictive guidelines. Data Collection/Extraction Methods Nonelderly adults (aged 19-64) in the BRFSS were linked to county unemployment rates from the Bureau of Labor Statistics' Local Area Unemployment Statistics Program. We created a Medicaid generosity index by simulating the share of a nationally representative sample of adults that would be eligible for Medicaid under each state's 2007 Medicaid guidelines using data from the 2007 Current Population Survey's Annual Social and Economic Supplement. Principal Findings A percentage point (PPT) increase in the county unemployment rate was associated with a 1.3 PPT (95% CI: 0.9-1.6, $P < .01$) increase in the likelihood of being uninsured and a 0.86 PPT (95% CI: 0.6-1.1, $P < .01$) increase in unmet medical needs due to cost in states with restrictive Medicaid eligibility guidelines. Conversely, a one PPT increase in unemployment was associated with only a 0.64 PPT ($P < .01$) increase in uninsurance among states with the most generous eligibility guidelines. Among states in the fourth quartile of generosity (ie, most generous), rises in county-level unemployment were associated with a 0.68 PPT ($P < .10$) increase in unmet medical needs due to cost—a 21% smaller decrease relative to states with the most restrictive Medicaid eligibility guidelines. Conclusions Increased access to Medicaid during the Great Recession mitigated the effects of increased unemployment on the rate of unmet medical need, particularly for adults with limited income.

► **« Unité précarité errance » : expérimentation d'un dispositif de soin pluridisciplinaire dédié aux femmes enceintes en errance**

BURKSAITYTE G., CHAPELAIN M., BARBEREAU C., *et al.*
2021

L'information psychiatrique 97(5): 360-366.

<https://www.cairn.info/revue-l-information-psychiatrique-2021-5-page-360.htm>

Les situations extrêmes de précarité constituent un facteur majeur de risque périnatal. Les auteurs décrivent un dispositif original, l'unité précarité errance (UPE), conçu pour des femmes en période périnatale vivant dans un contexte de dénuement, avec précarité, errance, migration, histoires polytraumatiques, dont ils décrivent les effets psychiques sur le processus de maternité. L'accompagnement psychologique prend place dans le dispositif pluridisciplinaire intégré médico- socio- psychologique offrant continuité et contenance. Le soin psychique montre une fonction de prévention de l'effondrement. Les possibilités d'élaboration favorisant la réorganisation psychique sont développées, de manière globale et avec l'appui d'un cas clinique.

► **Within and Across Country Variations in Treatment of Patients with Heart Failure and Diabetes**

OR Z., SHATROV K., PENNEAU A., *et al.*
2021

Health Services Research : Ahead of pub .

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13854>

The aim of this paper is to compare within-country variation of health care utilization and spending of patients with chronic heart failure (CHF) and diabetes across countries. Data Sources Patient-level linked data sources compiled by the International Collaborative on Costs, Outcomes, and Needs in Care across nine countries: Australia, Canada, England, France, Germany, New Zealand, Spain, Switzerland, and the United States. Data Collection Methods Patients were identified in routine hospital data with a primary diagno-

sis of CHF and a secondary diagnosis of diabetes in 2015/2016. **Study Design** We calculated the care consumption of patients after a hospital admission over a year across the care pathway—ranging from primary care to home health nursing care. To compare the distribution of care consumption in each country, we use Gini coefficients, Lorenz curves, and female–male ratios for eight utilization and spending measures. **Principal Findings** In all countries, rehabilitation and home nursing care were highly concentrated in the top decile of patients, while the number of drug prescriptions were more uniformly distributed. On average, the Gini coefficient for drug consumption is about 0.30 (95% confidence interval (CI): 0.27–0.36), while it is, 0.50 (0.45–0.56) for primary care visits, and more than 0.75 (0.81–0.92) for rehabilitation use and nurse visits at home (0.78; 0.62–0.9). Variations in spending were more pronounced than in utilization. Compared to men, women spend more days at initial hospital admission (+5%, 1.01–1.06), have a higher number of prescriptions (+7%, 1.05–1.09), and substantially more rehabilitation and home care (+20% to 35%, 0.79–1.6, 0.99–1.64), but have fewer visits to specialists (–10%; 0.84–0.97). **Conclusions** Distribution of health care consumption in different settings varies within countries, but there are also some common treatment patterns across all countries. Clinicians and policy makers need to look into these differences in care utilization by sex and care setting to determine whether they are justified or indicate suboptimal care.

► **Unmet Health Care Needs and Inequality: A Cross-Country Comparison of the Situation of People with Spinal Cord Injury**

PACHECO BARZALLO D., OÑA A. ET GEMPERLI A.
2021

Health Services Research : Ahead of pub.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13738>

The objective of this study is to estimate and compare unmet health care needs of persons with spinal cord injury (SCI) across countries, the causes of these shortfalls, and the role of income. **Data Sources** We analyzed cross-sectional data of 20 countries from the International Spinal Cord Injury (InSCI) survey, a compendium of comparable data on the living situation of persons with SCI. Data included information on high-, middle-, and low-income countries. The survey comprises information on 12,095 participants. **Study Design**

We used logit regressions to estimate the probability of unmet health care needs of persons with SCI and its causes. We adjusted the results by the individuals' characteristics and countries' fixed effects. We disaggregated the results by income decile of individuals in each country. **Data Collection/Extraction Methods** The inclusion criteria for the InSCI survey were adults aged 18 years and older with SCI living in the community, who were able to respond to the survey and who provided informed consent. **Principal Findings** Unmet health care needs are significant for people with long-term conditions like SCI, where people in low-income groups tend to be more affected. Among the barriers to meeting health care needs, the foremost is health care cost (in 11 of the 20 countries), followed by transportation and service availability. Persons with SCI in Morocco reported the highest probability of unmet health care needs in the sample, 0.54 (CI: 0.47–0.59), followed well behind by South Africa, 0.27 (CI: 0.20–0.33), and Brazil, 0.26 (CI: 0.20–0.33). In contrast, persons with SCI in Spain, 0.06 (CI: 0.04–0.08), reported the lowest probability of unmet health care needs, closely followed by Norway, 0.07 (CI: 0.05–0.09), Thailand, 0.08 (CI: 0.05–0.11), France, 0.08 (CI: 0.06–0.11), and Switzerland, 0.09 (CI: 0.07–0.10). **Conclusions** SCI is a long-term, irreversible health condition characterized by physical impairment and a series of chronic illness. This makes SCI a high-need, high-cost group that faces significant unmet health care needs, which are mainly explained by the costs of health services, transportation, and services availability. This situation is prevalent in low-, middle-, and high-income countries, where persons in lower income groups are disproportionately affected. To improve the situation, a combination of measures from the health and social systems are required.

Covid**► Area-Level Indicators of Income and Total Mortality During the Covid-19 Pandemic**COLOMBO F. R., ALICANDRO G. ET LA VECCHIA C.
2021**European Journal of Public Health 31(3): 625-629.**
<https://doi.org/10.1093/eurpub/ckab038>

There is mounting evidence that socioeconomic inequalities in mortality have widened during the Covid-19 pandemic. This study aimed at evaluating the relationship between area-level indicators of income and total mortality during the first phase of COVID-19 pandemic in the most hit Italian region. We conducted an ecological study based on the number of deaths registered in the municipalities of the Lombardy region (Italy) between January 2019 and June 2020. Municipalities were grouped according to quintiles of average income and pension of their resident population. Monthly age-standardized mortality ratios (MRs)

between the poorest and the richest municipalities and the corresponding 95% CI were computed to evaluate whether the pre-existing socioeconomic inequalities widened during the pandemic. Over the study period, 175 853 deaths were registered. During the pre-pandemic period (January 2019 to February 2020) the MR between the poorest and the richest municipalities ranged between 1.12 (95% CI: 1.00–1.25) and 1.33 (95% CI: 1.20–1.47). In March 2020, when the pandemic began to rapidly spread in the region, it raised up to 1.61 (95% CI: 1.51–1.72) and decreased thereafter, reaching the pre-pandemic values in April 2020. Similar results were observed in the analysis of the mortality at ages 65 and over in municipalities grouped according to average pension, where the MR increased up to 1.82 (95% CI: 1.70–1.94) in March 2020. The socioeconomic inequalities in mortality widened in Lombardy, the Italian region most severely hit during the first phase of the COVID-19 pandemic.

Médicament**Pharmaceuticals****► Dispositifs médicaux
« d'automédication » : les avantages pour
les industriels, des incertitudes pour
les patients. 1re partie : des dispositifs
médicaux ressemblant à des médicaments
mais sans AMM**

2021

Revue Prescrire 41(452): 456-461.

La réglementation européenne sur les dispositifs médicaux (DM), instaurée au début des années 1990, a notamment permis le développement d'un marché de produits composés exclusivement de substances chimiques, ayant une apparence de médicaments, mais échappant aux conditions d'une autorisation de mise sur le marché (AMM). Des principes d'action mécanique sont revendiqués pour les substances qui composent ces DM, écartant la possibilité d'un effet pharmacologique qui conduirait à donner au produit un statut de médicament. Il s'agit souvent d'ingrédients

de nature complexe aux propriétés floues, tels que des extraits végétaux.

**► Dispositifs médicaux
« d'automédication » : les avantages
pour les industriels, des incertitudes
pour les patients. 2e partie :
un marché peu contrôlé avant et après
commercialisation**

2021

Revue Prescrire 41(453): 532-537.

Les dispositifs médicaux qui imitent des médicaments, mais qui sont dénués d'AMM, sont pour la plupart commercialisés sur la base de niveaux de preuves cliniques très faibles. De nombreux dispositifs médicaux (DM) de soins courants, qui imitent l'apparence des médicaments d'automédication, ont été mis sur le marché sans l'aval d'une agence des produits de santé et sans

être munis d'une autorisation de mise sur le marché (AMM). Le nouveau règlement européen sur les DM applicable depuis le 26 mai 2021 instaure une période de grâce jusqu'en mai 2025 qui permet aux fabricants, sous conditions, de continuer à commercialiser leurs produits déjà sur le marché en conformité avec l'ancienne réglementation, moins exigeante. Les agences des produits de santé ont certes un rôle dans la surveillance du marché de ces DM, mais avec peu de moyens et peu d'effets. Il n'y a pas suffisamment de preuves de l'efficacité de ces produits, ni d'informations complètes sur leur composition, ni de notices informant les patients et garantissant leur protection. Une prudence particulière s'impose chez les enfants et les femmes enceintes ou qui pourraient le devenir, d'autant que très peu de données publiques sont à disposition des consommateurs, ou des soignants qui souhaitent les informer. La publicité et les allégations parfois fantaisistes voire trompeuses de ces DM sont peu contrôlées, alors que l'accès à ces produits est libre y compris en ligne : pharmacies, parapharmacies, plateformes mondiales de e-commerce. Ni la directive en vigueur jusqu'à mi-2021, ni le nouveau règlement européen ne s'opposent à ce qu'un DM ressemble à un médicament. Une lecture attentive de l'étiquetage permet de savoir si un produit ressemblant à un médicament est en fait un DM ou non : en France, sur la boîte d'un médicament figure, souvent au dos ou sur une tranche en petits caractères, la mention « médicament autorisé n° » suivi de 13 chiffres commençant toujours par 34009.

► **Use of Self-Tests and Rapid Diagnostic Tests: Survey of Dispensing Pharmacists in the Auvergne-Rhône-Alpes Region**

BOULLIAT C., BILONG C. V., DUSSART C., *et al.*
2021

Ann Pharm Fr 79(5): 547-557.

RDT and self-tests are sold in pharmacies. These are medical biology procedures that are currently reserved for biologists. Nevertheless, their use is now being reinforced by the Covid-19 pandemic. What role should the dispensing pharmacist have in relation to the patient? What role can the biologist have in this system? A survey was carried out in pharmacies in the Auvergne-Rhône-Alpes region, as well as in Cameroon during the summer of 2020, to evaluate the use of RDT and self-tests. The answers obtained to the 10 questions were discussed after a simple statistical analysis. RESULTS: Two hundred and eighty-three pharmacies and 13 Cameroonian pharmacies participated in our

survey. Pharmacists want to develop the use of RDT and self-test, but agree that training is necessary. Some tests are dispensed despite their unproven clinical usefulness. The delivery of TRODs and self-tests is acquired in pharmacies despite the reluctance of biologists. Pharmacists should be trained by biologists to use these tests in a relevant and appropriate manner.

► **Potentially Inappropriate Prescriptions: Associations with the Health Insurance Contract and the Quality of the Patient-Physician Relationship?**

CHAUVIN P., FUSTINONI S., SEEMATTER-BAGNOUD L., *et al.*

2021

Health Policy : 125(9) : 1146-1157

<https://doi.org/10.1016/j.healthpol.2021.06.011>

Potentially Inappropriate Prescriptions (PIP) are often used as an indicator of potential drug overuse or misuse to limit adverse drug events in older people. The aim of this paper is to determine whether PIP exposure differs as a function of the patient's health insurance scheme and the patient-physician relationship. Methods Our dataset was collected from two surveys delivered to two cohorts of the Swiss Lc65+ study, together with a stratified random sample of older people in the Swiss canton of Vaud. The study sample consisted of 1,595 people aged 68 years and older living in the community and reporting at least one prescription drug. Logit regression models of PIP risk were run for various categories of variables: health related, socioeconomic, health insurance scheme and patient-physician relationship. Results 17% of our respondents had at least one PIP. Our results suggested that being enrolled in a health plan with restriction in the patient's choice of providers and having higher deductibles were associated with lower PIP risk. PIP risk did not differ as a function of the quality of the patient-physician relationship. Conclusion Our study helps to raise awareness about the organizational risk factors of PIP and, more specifically, how health insurance contracts could play a role in improving the management of drug consumption among community-dwelling older people.

► **An Open Science Pathway For Drug Marketing Authorization-Registered Drug Approval**

NAUDET F., SIEBERT M., BOUSSAGEON R., *et al.*
2021

PLoS medicine 18(8): e1003726-e1003726.

<https://pubmed.ncbi.nlm.nih.gov/34370737>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8351924/>

Florian Naudet and co-authors propose a pathway involving registered criteria for evaluation and approval of new drugs.

► **Paediatric Outpatient Prescriptions in France Between 2010 and 2019: A Nationwide Population-Based Study: Paediatric Outpatient Prescriptions in France, 2010 to 2019**

TAINE M., OFFREDO L., DRAY-SPIRA R., *et al.*
2021

The Lancet Regional Health - Europe 7: 100129.

<https://doi.org/10.1016/j.lanepe.2021.100129>

Paediatric outpatient prescription (POP) monitoring is pivotal to identify inadequate prescriptions and optimize drug use. We aimed at describing recent trends in POPs in France. Methods All reimbursed dispensations of outpatient prescribed drugs (excluding vaccines) were prospectively collected for the paediatric population (<18 years old) in the French national health data-

base in 2010–2011 and 2018–2019 (mean 117,356,938/year). POP prevalence (proportion of children receiving ≥ 1 drug prescriptions/year) was calculated by age groups and compared by prevalence rate ratios (PRRs). Given the large sample size, 95% confidence intervals of POP prevalences and PRRs did not differ from estimates. Findings Among the 14,510,023 children resident in France in 2018–2019, mean POP prevalence was 857‰ children. Most prescribed therapeutic classes were analgesics (643‰), antibiotics (405‰), nasal corticosteroids (328‰), nonsteroidal anti-inflammatory drugs (NSAIDs) (244‰), antihistamines (246‰) and systemic corticosteroids (210‰). POPs decreased with age from 976‰ for infants to 782‰ for adolescents. Children <6 years old were notably more exposed to inhaled corticosteroids (PRR = 3.06), non-penicillin beta-lactam antibacterial agents (PRR = 3.05) and systemic corticosteroids (PRR = 2.11) than older ones. The POP prevalence was slightly higher (PRR = 1.04) during 2018–2019 than 2010–2011, with marked increases for anti-emetics (PRR = 1.84), vitamin D (PRR = 1.49), proton pump inhibitors (PRR = 1.42), systemic contraceptives (PRR = 1.24) and nasal corticosteroids (PRR = 1.21) and decreases for propulsive/prokinetic agents (PRR = 0.09), NSAIDs (PRR = 0.73) and systemic antibiotics (PRR = 0.88). Interpretation POP remained highly prevalent in France throughout the 2010s, especially for children <6 years old, with only a few improvements for selected therapeutic classes. These findings should prompt clinical guidance campaigns and/or regulatory policies. Funding Internal funding

Méthodologie – Statistique

Methodology - Statistics

► **Algorithmes d'identification des rhumatismes inflammatoires chroniques et du psoriasis dans les bases médico-administratives : revue de la littérature**

CASTAGNÉ B., VIPREY M., CAILLET-PASCAL P., *et al.*
2021

Revue d'Epidémiologie et de santé publique 69(4): 225-233.

<https://doi.org/10.1016/j.respe.2021.02.002>

L'objectif de cette revue de la littérature était de décrire

et discuter les algorithmes utilisés pour la détection des rhumatismes inflammatoires chroniques (RIC) et du psoriasis dans les bases de données médico-administratives (BDMA). Nous avons réalisé une revue de la littérature dans la base de données Medline et recherché tous les articles publiés dans cette base de données jusqu'au 31 janvier 2018 inclus. Nos critères d'inclusion étaient : les articles originaux d'études menées sur des BDMA, quel que soit l'objectif principal, rédigés en anglais ou en français, traitant d'au moins une des quatre pathologies étudiées (PR, SA, RPso et Pso) et utilisant la codification de la Classification

internationale des maladies, version 10 (CIM-10). Les critères de non-inclusion étaient : les lettres à la rédaction, les commentaires d'articles publiés, les études ayant utilisé d'autres codes que ceux de la CIM ou bien une version antérieure. Résultats Parmi les 590 références identifiées, 37 articles ont été inclus. Pour la PR (n=10), toutes les études ont utilisé le code M05, 6/10 ont en plus utilisé le code M06 dans sa globalité. Les quatre études restantes ont ciblé spécifiquement les codes M06.0, M06.2, M06.3, M06.8, M06.9 et deux d'entre elle ont également utilisé le code M12.3. Pour la SA (n=8), sept études ont utilisé le code M45; seule une étude a utilisé les codes M45.9, M46.1 et M46.8. Pour le Pso (n=17), tous les auteurs ont utilisé le code L40 et/ou 2 prescriptions de vitamine D topique. Toutes les études sur le RPso (n=13) ont utilisé les mêmes codes : M07.0, M07.1 M07.2, M07.3. Conclusion Nous recommandons d'utiliser les codes M05 et M06 (à l'exclusion des codes M06.1 et M06.4) pour la PR, les codes M45 pour la SA, l'algorithme « L40 et/ou 2 dispensations de vitamine D topique » pour le Pso, et les codes M070 à M073 pour le RPso..

► **Analyse en réseau par fouille de données textuelles systématique du concept de psychiatrie personnalisée et de précision**

GAULD C. ET MICOULAUD-FRANCHI J. A.
2021

L'Encéphale 47(4): 341-347.

<https://doi.org/10.1016/j.encep.2020.08.008>

La médecine personnalisée et de précision nécessite une clarification des concepts qui y sont rattachés. À notre connaissance, il n'existe pas d'exploration systématique de la littérature portant sur les dimensions et les concepts de la psychiatrie personnalisée et de précision et sur leurs usages dans les domaines neuroscientifiques et génétiques. Cet article propose donc d'explorer les dimensions et les concepts de la psychiatrie personnalisée et de précision. Méthodes Une analyse en réseau par fouille de données textuelles systématique issue d'une revue exhaustive de la littérature internationale autour des termes de "precision psychiatry" et de "personalized psychiatry" a été réalisée. Cette fouille de données textuelles a été représentée sous forme d'un réseau permettant d'analyser les dimensions et les concepts de la psychiatrie personnalisée et de précision. Résultats La psychiatrie personnalisée et de précision renvoie à six dimensions retrouvées au sein de l'analyse du réseau textuel. Ces

six dimensions correspondent aux domaines scientifiques qui étudient la psychiatrie personnalisée et de précision, à savoir : la génétique, la pharmacogénétique, les approches computationnelles, le raffinement des essais thérapeutiques, les biomarqueurs et la stadification. L'analyse des termes renvoie à un ensemble de concepts hétérogènes. Conclusions L'hétérogénéité retrouvée dans la littérature sur la psychiatrie personnalisée et de précision peut témoigner d'un manque d'un cadre théorique pluraliste et intégratif. Ce cadre de travail pourrait être basé sur un formalisme naturalisant mais non réducteur, conscient des enjeux sociétaux des sciences et de leur implémentation dans les dispositifs de recherche et cliniques de la psychiatrie.

► **Application of Mixed Methods in Health Services Management Research: A Systematic Review**

LEE S.-Y. D., LOTT B., BANASZAK-HOLL J., *et al.*
2021

Medical Care Research and Review : Ahead of pub.

<https://journals.sagepub.com/doi/abs/10.1177/10775587211030393>

Mixed methods research (MMR) is versatile, pragmatic, and adaptable to constraints and opportunities during a research process. Although MMR has gain popularity in health services management research, little is known about how the research approach has been used and the quality of research. We conducted a systematic review of 198 MMR articles published in selected U.S.-based and international health services management journals from 2000 through 2018 to examine the extent of MMR application and scientific rigor. Results showed limited, yet increasing, use of MMR and a high degree of correspondence between MMR designs and study purposes. However, most articles did not clearly justify using MMR designs and the reporting of method details and research integration were inadequate in a significant portion of publications. We propose a checklist to assist the preparation and review of MMR manuscripts. Additional implications and recommendations to improve transparency, rigor, and quality in MMR are discussed.

Health Policy**► Aligning Health Care and Social Services to Reduce Hospitalizations and Emergency Department Visits: An Evaluation of the Community Care Connections Program**AKIYA K., FISHER E., WELLS A., *et al.*
2021**Medical Care 59(8): 671-678.**https://journals.lww.com/lww-medicalcare/Fulltext/2021/08000/Aligning_Health_Care_and_Social_Services_to_Reduce.2.aspx

Background: Integration of social services in health care delivery is increasingly recognized as a potential strategy for improving health and reducing the use of acute care services. Collaborative models that provide older adults with case management, linkages to social services, and assistance with health care navigation have emerged as promising strategies. Objective: The objective of this study was to evaluate the Community Care Connections (CCC) program, a cross-sector collaboration designed to align social and health care services for older adults. Research Design: We compared hospitalizations and emergency department (ED) visits 90 days after enrollment with a propensity score-matched group of non-CCC patients. Subgroup analyses were also conducted for adults with hypertension, diabetes, and high cholesterol. Subjects: A total of 1004 patients enrolled in CCC between June 1, 2016, and November 15, 2018, and 1004 matched patients from the same metropolitan area. Measures: Mean hospitalizations and ED visits per patient 90 days after CCC enrollment. Results: Mean hospitalizations were lower among CCC patients 90 days after enrollment than among non-CCC adults [difference = -0.039, 95% confidence interval (CI): -0.077 to -0.001, P = 0.044]. They were also lower among CCC patients with hypertension (difference = -0.057, 95% CI: -0.103 to -0.010, P = 0.017). However, 90 days after enrollment mean ED visits were higher among CCC patients relative to non-CCC adults (difference = 0.238, 95% CI: 0.195-0.281, P < 0.001). Conclusions: Connecting older adults to social services while being served by the health care system may lead to decreases in hospitalizations. Cross-sector partnerships that address social and economic needs may reduce the use of costly health care services.

► Nous avons des institutions de sécurité sanitaire, mais pas de politique de sécurité sanitaireDAB W.
2021**Revue française des affaires sociales(2): 91-96.**<https://www.cairn.info/revue-francaise-des-affaires-sociales-2021-2-page-91.htm>

Cet article présente la position de W. Dab, ancien directeur de la Direction générale de la santé, et à la retraite au moment où l'épidémie de Covid se répand. Son rôle dans ce dossier a été notamment d'intervenir dans le débat public, notamment pour souligner l'importance d'être prudent en situation d'incertitude.

► La sédation profonde et continue maintenue jusqu'au décès, à domicile, en médecine généraleDENOS M., GIMENEZ L., DELAHAYE M., *et al.*
2021**Médecine : De La Médecine Factuelle à Nos Pratiques 17(5): 216-224.**https://www.jle.com/fr/revues/med/e-docs/la_sedation_profonde_et_continue_maintenue_jusquau_decès_a_domicile_en_medecine_generale_320546/article.phtml

Depuis le 2 février 2016, la loi Claeys-Leonetti définit la sédation profonde et continue maintenue jusqu'au décès (SPCMD) et ouvre le droit au patient d'en bénéficier sous certaines conditions, lorsque son pronostic vital est engagé à court terme. En février 2020, la ministre de la Santé a annoncé que le midazolam, la molécule recommandée pour induire la sédation, serait prochainement disponible dans les pharmacies de ville, à disposition des médecins généralistes (MG). La SPCMD est une procédure qui doit pouvoir être proposée aux patients à domicile qui le souhaitent et la nécessitent dans de bonnes conditions.

► **Le service sanitaire, levier d'une identité professionnelle intégrant la santé primaire**

DUBOIS G. ET VERHEYE J. C.
2021

Cahiers de Santé Publique Et de Protection Sociale (Les)(37): 5.

<https://cahiersdesante.fr/editions/le-service-sanitaire-levier-dune-identite-professionnelle-integrant-la-sante-primaire-2/>

L'évolution du système de santé plaide en faveur d'un renforcement des actions de santé primaire dans les lieux de soins. Le développement effectif de la prévention implique une évolution de l'identité professionnelle soignante, encore dominée par une approche curative. Le Service sanitaire, en contribuant à développer une posture préventive dès la formation initiale, constitue un levier important de transformation des identités et des pratiques, mais également une occasion pour les structures de soin regroupés de tisser de nouveaux partenariats.

► **The Impact of Patient and Public Involvement in Health Research Versus Healthcare: A Scoping Review of Reviews**

MODIGH A., SAMPAIO F., MOBERG L., *et al.*
2021

Health Policy 125(9) : 1208-1221

<https://doi.org/10.1016/j.healthpol.2021.07.008>

Many policies promote a patient and public involvement (PPI) in health research and healthcare provision. However, research points to uncertainties about its impact. The aim of the article was to compare what types of impact have been reported in reviews of PPI in health research and healthcare, respectively, and to map differences and similarities between the review studies. A review of reviews was undertaken with a search strategy based on the PCC mnemonic for scoping reviews. Four online databases were searched. Studies published in English between the years 2000-2020, using a review-based method and aiming to demonstrate impact of PPI were included, resulting in sixty-one articles. More reviews of PPI impact in healthcare than in health research were found, although the latter included a larger number of empirical studies. Systematic reviews, quality assessment and quantitative studies were less common in health research. Many original studies were from the United Kingdom. In health research, reported impacts most often related to research design and delivery, while in healthcare

the most commonly reported impacts were individual health outcomes/clinical outcomes. However, there is still uncertainty about the strength of evidence for PPI, in particular when it comes to collective involvement in healthcare, that is in policymaking and service improvement initiatives at hospitals or the like.

► **Étude d'un dispositif en interfiliarité dans le cadre du Service sanitaire des étudiants en santé : conception, mise en œuvre et perspectives**

PEREZ-ROUX T.
2021

Recherche en soins infirmiers 145(2): 65-78.

<https://www.cairn.info/revue-recherche-en-soins-infirmiers-2021-2-page-65.htm>

Dans le cadre du Service sanitaire des étudiants en santé (SEES), des étudiants en masso-kinésithérapie (MK) et en soins infirmiers (SI) d'un même territoire ont été réunis pour participer à un dispositif expérimental. Les étudiants de chaque filière n'étant pas habitués à travailler ensemble, il a été nécessaire pour les formateurs de s'organiser afin de créer un environnement pédagogique favorable. Cette contribution s'intéresse à « ce qui s'est joué » dans la mise en place d'un tel dispositif. Des entretiens semi-directifs ont été réalisés avec l'équipe de direction de l'IFMK-L, au début de l'année 2019-2020, et avec les formateurs/formatrices en MK et SI impliqués dans deux des dispositifs, au terme de l'expérimentation. Les données ont été traitées par une analyse thématique du discours. Au-delà des enjeux d'un tel dispositif, les résultats prennent en compte la manière dont celui-ci a été vécu par les formateurs/formatrices. Des cultures de formation assez contrastées et des positionnements identitaires sont révélés à travers le retour sur l'expérience. L'ensemble du travail permet de repérer les leviers, les freins, les conditions optimales de mise en place de ce type d'action de prévention en interfiliarité et ouvre sur de nouveaux enjeux de formation.

Covid**► Healthcare System and Social Trust in the Fight Against Covid-19: The Case of France**AMDAOUD M., ARCURI G. ET LEVRATTO N.
2021**European Journal of Public Health : 31(4):895–900.**
<https://doi.org/10.1093/eurpub/ckab112>

Covid-19, like all pandemics, has territorial specificities that need to be considered: the impact of the Covid-19 crisis strongly differs not only across countries, but also across regions, districts and municipalities within countries. There are several factors that, potentially, can contribute to the differentiated impact of COVID-19, and explain the disparities seen among areas. This study aims to contribute to this debate by analyzing the role of health system and social trust in lessening the impact of the COVID-19 pandemic in French 'départements'. The data used in this study have been provided by the INSEE and the French Ministry of Health. Database is made up of the 96 'départements' of metropolitan France. We use spatial analysis techniques to identify the groups of areas that are particularly affected, and to test the influence of local socio-economic factors on the spread of the epidemic. Our exploratory spatial analysis reveals the heterogeneity and spatial autocorrelation of the disease. The use of spatial econometric models, then, allows us to highlight the impact of emergency services, and social capital in reducing the exposition to Covid-19. Our results also report on the role of spillover effects between neighbouring areas. This research shows that, although individual characteristics are important factors in explaining the probability of contracting Covid-19 disease, health care services and social trust factors also play a significant role in curbing the epidemic's outbreak. These findings should have an interest for policy makers in the prevention of future waves of COVID-19 pandemic.

► A Comparison of Health Policy Responses to the COVID-19 Pandemic in Canada, Ireland, the United Kingdom and the United States of AmericaUNRUH L., ALLIN S., MARCHILDON G., *et al.*
2021**Health Policy : Ahead of pub.**
<https://doi.org/10.1016/j.healthpol.2021.06.012>

This paper compares health policy responses to COVID-19 in Canada, Ireland, the United Kingdom and United States of America (US) from January to November 2020, with the aim of facilitating cross-country learning. Evidence is taken from the COVID-19 Health System Response Monitor, a joint initiative of the European Observatory on Health Systems and Policies, the WHO Regional Office for Europe, and the European Commission, which has documented country responses to COVID-19 using a structured template completed by country experts. We show all countries faced common challenges during the pandemic, including difficulties in scaling-up testing capacity, implementing timely and appropriate containment measures amid much uncertainty and shortages of health and social care workers, personal protective equipment and other medical technologies. Country responses to address these issues were similar in many ways, but dissimilar in others, reflecting differences in health system organization and financing, political leadership and governance structures. In the US, lack of universal health coverage may also have created barriers to accessing care, while political pushback against scientific leadership has likely undermined the crisis response. Our comparative analysis highlights a number of factors that are central to an effective pandemic response: appropriate containment and mitigation measures; strong and consistent leadership; evidence-based, transparent decision making; coordinated test, trace and isolate systems; universal coverage; and a sufficient health and social care workforce.

Covid

► **La stratégie suédoise en matière de lutte contre le Covid-19 : une forte tradition de santé publique et une approche holistique de la santé**

ACKER D.
2021

Revue Française des Affaires sociales(2): 101-123.

<https://www.cairn.info/revue-francaise-des-affaires-sociales-2021-2-page-101.htm>

► **Comparing the Impact on COVID-19 Mortality of Self-Imposed Behavior Change and of Government Regulations Across 13 Countries**

JAMISON J. C., BUNDY D., JAMISON D. T., *et al.*
2021

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

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13688>

Abstract Objective Countries have adopted different approaches, at different times, to reduce the transmission of coronavirus disease 2019 (COVID-19). Cross-country comparison could indicate the relative efficacy of these approaches. We assess various nonpharmaceutical interventions (NPIs), comparing the effects of voluntary behavior change and of changes enforced via official regulations, by examining their impacts on subsequent death rates. Data Sources Secondary data on COVID-19 deaths from 13 European countries, over March–May 2020. Study Design We examine two types of NPI: the introduction of government-enforced closure policies and self-imposed alteration of individual behaviors in the period prior to regulations. Our proxy for the latter is Google mobility data, which captures voluntary behavior change when disease salience is sufficiently high. The primary outcome variable is the rate of change in COVID-19 fatalities per day, 16–20 days after interventions take place. Linear multivariate regression analysis is used to evaluate impacts. Data collection/extraction methods: publicly available. Principal Findings Voluntarily reduced mobility, occurring prior to government policies,

decreases the percent change in deaths per day by 9.2 percentage points (pp) (95% confidence interval [CI] 4.5–14.0 pp). Government closure policies decrease the percent change in deaths per day by 14.0 pp (95% CI 10.8–17.2 pp). Disaggregating government policies, the most beneficial for reducing fatality, are intercity travel restrictions, canceling public events, requiring face masks in some situations, and closing nonessential workplaces. Other sub-components, such as closing schools and imposing stay-at-home rules, show smaller and statistically insignificant impacts. Conclusions NPIs have substantially reduced fatalities arising from COVID-19. Importantly, the effect of voluntary behavior change is of the same order of magnitude as government-mandated regulations. These findings, including the substantial variation across dimensions of closure, have implications for the optimal targeted mix of government policies as the pandemic waxes and wanes, especially given the economic and human welfare consequences of strict regulations.

► **Covid-19 Pandemic and Its Impact on Social Relationships and Health**

LONG E., PATTERSON S., MAXWELL K., *et al.*
2021

Journal of Epidemiology and Community Health: jech-2021-216690.

<https://jech.bmj.com/content/jech/early/2021/08/18/jech-2021-216690.full.pdf>

This essay examines key aspects of social relationships that were disrupted by the COVID-19 pandemic. It focuses explicitly on relational mechanisms of health and brings together theory and emerging evidence on the effects of the Covid-19 pandemic to make recommendations for future public health policy and recovery. We first provide an overview of the pandemic in the UK context, outlining the nature of the public health response. We then introduce four distinct domains of social relationships: social networks, social support, social interaction and intimacy, highlighting the mechanisms through which the pandemic and associated public health response drastically altered social inter-

actions in each domain. Throughout the essay, the lens of health inequalities, and perspective of relationships as interconnecting elements in a broader system, is used to explore the varying impact of these disruptions. The essay concludes by providing recommendations for longer term recovery ensuring that the social relational cost of COVID-19 is adequately considered in efforts to rebuild. Data sharing not applicable as no data sets generated and/or analysed for this study. Data sharing not applicable as no data sets generated or analysed for this essay.

► **Belgium's Response to the Covid-19 Pandemic**

LUYTEN J. ET SCHOKKAERT E.
2021

Health Economics, Policy and Law: 1-11.

<https://doi.org/10.1017/S1744133121000232>

Belgium is often seen as an outlier in the international experience with the coronavirus disease 2019. We summarize the unfolding of the pandemic in Belgium from February to December 2020, discuss the countermeasures that were implemented and provide some explanations why the numbers indicate a stronger pandemic in Belgium than in its neighbouring countries. To some extent, the seemingly poor performance of Belgium is a measurement artefact. Yet, there were indeed particular factors in Belgium that unnecessarily increased the toll of the pandemic. In the first wave insufficient priority was given to protect care homes. The second wave was larger than necessary due to a failure to timely implement restrictive measures. The latter can, at least partly, be explained by a unique political situation: a temporary, minority government in the middle of a major crisis.

► **The Effectiveness of National-Level Containment and Closure Policies Across Income Levels During the COVID-19 Pandemic: An Analysis of 113 Countries**

PINCOMBE M., REESE V. ET DOLAN C. B.
2021

Health Policy and Planning 36(7): 1152-1162.

<https://doi.org/10.1093/heapol/czab054>

Despite heterogeneity in income levels, countries implemented similarly strict containment and closure policies to mitigate the COVID-19 pandemic. This research assesses the effectiveness of these contain-

ment and closure policies, which we defined as larger decreases in mobility and smaller COVID-19 case and death growth rates. Using daily data for 113 countries on mobility and cumulative COVID-19 case and death counts over the 130 days between February 15, 2020 and June 23, 2020, we examined changes in mobility, morbidity, and mortality growth rates across the World Bank's income group classifications. Containment policies correlated with the largest declines in mobility in higher income countries. High-income countries also achieved lower COVID-19 case and death growth rates than low-income countries. This study finds better epidemiological outcomes of containment and closure policies for higher income countries than lower income countries. These findings urge policymakers to consider contextual differences, including levels of economic activity and the structure of the economy, when crafting policies in response to public health emergencies.

► **Nordic Responses to Covid-19: Governance and Policy Measures in the Early Phases of the Pandemic**

SAUNES I. S., VRANGBÆK K., BYRKJEFLOT H., *et al.*
2021

Health Policy : Ahead of pub.

<https://doi.org/10.1016/j.healthpol.2021.08.011>

This paper explores and compares health system responses to the COVID-19 pandemic in Denmark, Finland, Iceland, Norway and Sweden, in the context of existing governance features. Content compiled in the Covid-19 Health System Response Monitor combined with other publicly available country information serve as the foundation for this analysis. The analysis mainly covers early response until August 2020, but includes some key policy and epidemiological developments up until December 2020. Our findings suggest that despite the many similarities in adopted policy measures, the five countries display differences in implementation as well as outcomes. Declaration of state of emergency has differed in the Nordic region, whereas the emphasis on specialist advisory agencies in the decision-making process is a common feature. There may be differences in how respective populations complied with the recommended measures, and we suggest that other structural and circumstantial factors may have an important role in variations in outcomes across the Nordic countries. The high incidence rates among migrant populations and temporary migrant workers, as well as differences in working conditions are important factors to explore further. An important question

for future research is how the COVID-19 epidemic will influence legislation and key principles of governance in the Nordic countries.

► **Australia's Response to Covid-19**

STOBART A. ET DUCKETT S.
2021

Health Economics, Policy and Law: 1-12.

<https://doi.org/10.1017/S1744133121000244>

Australia suffered two waves of the coronavirus disease 2019 pandemic in 2020: the first lasting from February to July 2020 was mainly caused by transmission from international arrivals, the second lasting from July to November was caused by breaches of hotel quarantine which allowed spreading into the community. From a second wave peak in early August of over 700 new cases a day, by November 2020 Australia had effectively eliminated community transmission. Effective elimination was largely maintained in the first half of 2021 using snap lockdowns, while a slow vaccination programme left Australia lagging behind comparable countries. This paper describes the interventions which led to Australia's relative success up to July 2021, and also some of the failures along the way.

► **A Comparison of Health Policy Responses to the COVID-19 Pandemic in Canada, Ireland, the United Kingdom and the United States of America**

UNRUH L., ALLIN S., MARCHILDON G., *et al.*
2021

Health Policy.

<https://doi.org/10.1016/j.healthpol.2021.06.012>

This paper compares health policy responses to COVID-19 in Canada, Ireland, the United Kingdom and United States of America (US) from January to November 2020, with the aim of facilitating cross-country learning. Evidence is taken from the COVID-19 Health System Response Monitor, a joint initiative of the European Observatory on Health Systems and Policies, the WHO Regional Office for Europe, and the European Commission, which has documented country responses to COVID-19 using a structured template completed by country experts. We show all countries faced common challenges during the pandemic, including difficulties in scaling-up testing capacity, implementing timely and appropriate containment measures amid much uncertainty and shortages of health and social care

workers, personal protective equipment and other medical technologies. Country responses to address these issues were similar in many ways, but dissimilar in others, reflecting differences in health system organization and financing, political leadership and governance structures. In the US, lack of universal health coverage may also have created barriers to accessing care, while political pushback against scientific leadership has likely undermined the crisis response. Our comparative analysis highlights a number of factors that are central to an effective pandemic response: appropriate containment and mitigation measures; strong and consistent leadership; evidence-based, transparent decision making; coordinated test, trace and isolate systems; universal coverage; and a sufficient health and social care workforce.

► **A Comparative Study of Public Health and Social Measures of Covid-19 Advocated in Different Countries**

WANG D. ET MAO Z.
2021

Health Policy 125(8): 957-971.

<https://doi.org/10.1016/j.healthpol.2021.05.016>

Coronavirus 2019 (COVID-19) has had a significant impact on the world. Different countries introduced various public health and social measures (PHSMs) against the coronavirus. This paper aims to (a) examine how national policies on PHSMs were framed and which PHSMs were adopted; (b) compare the similarities and differences of PHSMs advocated by different countries; and (c) examine whether these measures have changed with time. We performed a content analysis of 160 COVID-19 policy documents on the websites of the WHO and ten countries' government websites on Covid-19 between December 1, 2019 and May 31, 2020. Results showed that although the initial responses to Covid-19 in different countries varied, there was a homogenization of PHSMs over time: by May 31, 2020, almost all the countries we studied implemented the major PHSMs that the WHO recommended, except Sweden, which applied only part of the major PHSMs recommended by the WHO. The differences among countries were in the speediness, strictness and resourcefulness of the PHSMs implementation. We suggest that a timely and effective utilization of the integrated package of health measures with the support of adequate resources may help the efficient implementation of PHSMs.

► **Soft Law and Individual Responsibility: A Review of the Swedish Policy Response to Covid-19**

WINBLAD U., SWENNING A.-K. ET SPANGLER D.
2021

Health Economics, Policy and Law: 1-14.

<https://doi.org/10.1017/S1744133121000256>

Sweden's coronavirus disease 2019 (Covid-19) response, initially based largely on voluntary measures, has evoked strong reactions nationally and internationally. In this study, we describe Sweden's national policy response with regard to the general public, the community and the health care system, with a focus on how the response changed from March 2020 to June 2021. A number of factors contributed to Sweden's choice of policy response, including its existing legal framework, independent expert agencies and its decentralized, multi-level health care governance system. Challenges to the health- and elder care system during the pandemic, such as the need to increase intensive care- and testing capacity, and to ensure the safety of the elderly were addressed largely at the regional and local levels, with national authorities assuming a primarily coordinative role. Although the overall response based on voluntary compliance has persisted, the national government started to take a more prominent role in public messaging, and in enacting legally binding restrictions during subsequent waves of the pandemic. This study illustrates that not only policy responses, but also the fundamental structure of the health- and elder care system and its governance should be considered when evaluating the impact of the COVID-19 pandemic.

► **European Countries' Responses in Ensuring Sufficient Physical Infrastructure and Workforce Capacity During the First Covid-19 Wave**

WINKELMANN J., WEBB E., WILLIAMS G. A., *et al.*
2021

Health Policy.

<https://doi.org/10.1016/j.healthpol.2021.06.015>

The Covid-19 pandemic has placed unprecedented pressure on health systems' capacities. These capacities include physical infrastructure, such as bed capacities and medical equipment, and healthcare professionals. Based on information extracted from the COVID-19 Health System Reform Monitor, this paper analyses the strategies that 45 countries in Europe have taken to secure sufficient health care infrastructure and workforce capacities to tackle the crisis, focusing on the hospital sector. While pre-crisis capacities differed across countries, some strategies to boost surge capacity were very similar. All countries designated COVID-19 units and expanded hospital and ICU capacities. Additional staff were mobilised and the existing health workforce was redeployed to respond to the surge in demand for care. While procurement of personal protective equipment at the international and national levels proved difficult at the beginning due to global shortages, countries found innovative solutions to increase internal production and enacted temporary measures to mitigate shortages. The pandemic has shown that coordination mechanisms informed by real-time monitoring of available health care resources are a prerequisite for adaptive surge capacity in public health crises, and that closer cooperation between countries is essential to build resilient responses to Covid-19.

Prévention

Prevention

► **Social Inequalities in Participation in Cancer Screening: Does the Mode of Data Collection Matter? the CONSTANCES Cohort**

ARANDA E., FRANCK J.-E., RINGA V., *et al.*
2021

European Journal of Public Health 31(3): 602-608.

<https://doi.org/10.1093/eurpub/ckab055>

Self-reported data are prone to item non-response and misreporting. We investigated to what extent the use of self-reported data for participation in breast (BCS) and cervical cancer screening (CCS) impacted socioeconomic inequalities in cancer screening participation. We used data from a large population-based

survey including information on cancer screening from self-reported questionnaire and administrative records (n = 14 122 for BCS, n = 27 120 CCS). For educational level, occupation class and household income per capita, we assessed the accuracy of self-reporting using sensitivity, specificity and both positive and negative predictive value. In addition, we estimated to what extent the use of self-reported data modified the magnitude of socioeconomic differences in BCS and CCS participation with age-adjusted non-screening rate difference, odds ratios and relative indices of inequality. Although women with a high socioeconomic position were more prone to report a date for BCS and CCS in questionnaires, they were also more prone to over-declare their participation in CCS if they had not undergone a screening test within the recommended time frame. The use of self-reported cancer screening data, when compared with administrative records, did not impact the magnitude of social differences in BCS participation but led to an overestimation of the social differences in CCS participation. This was due to misreporting rather than to item non-response. Women's socioeconomic position is associated with missingness and the accuracy of self-reported BCS and CCS participation. Social inequalities in cancer screening participation based on self-reports are likely to be overestimated for CCS.

► **Effects of the Colorectal Cancer Control Program**

BITLER M. P., CARPENTER C. S. ET HORN D.
2021

Health Economics: Ahead of pub.

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4397>

Although colorectal cancer (CRC) screening is highly effective, screening rates lag far below recommended levels, particularly for low-income people. The Colorectal Cancer Control Program (CRCCP) funded \$100 million in competitively awarded grants to 25 states from 2009–2015 to increase CRC screening rates among low-income, uninsured populations, in part by directly providing and paying for screening services. Using data from the 2001–2015 Behavioral Risk Factor Surveillance System (BRFSS) and a difference-in-differences strategy, we find no effects of CRCCP on the use of relatively cheap fecal occult blood tests (FOBT). We do, however, find that the CRCCP significantly increased the likelihood that uninsured 50–64-year-olds report ever having a relatively expensive endoscopic CRC screening (sigmoidoscopy or colonoscopy)

by 2.9 percentage points, or 10.7%. These effects are larger for women, minorities, and individuals who did not undertake other types of preventive care. We do not find that the CRCCP led to significant changes in CRC cancer detection. Our results indicate that the CRCCP was effective at increasing CRC screening rates among the most vulnerable.

► **Médecine personnalisée et prévention des maladies chroniques : l'attitude des médecins généralistes**

CARDINAUX R., COHIDON C., GUESSOUS I., *et al.*
2021

Santé Publique 33(1): 121-126.

<https://www.cairn.info/revue-sante-publique-2021-1-page-121.htm>

Dans un contexte de future généralisation de l'accès aux profils génétiques de risque, les médecins généralistes auront un rôle majeur à jouer. L'objectif de cette étude était de connaître leur attitude par rapport à cette démarche et aux potentielles conséquences sur leur pratique. Méthodes : En 2018, le centre universitaire de médecine générale et de santé publique de Lausanne, le Service de médecine de premier recours des hôpitaux universitaires de Genève et l'Institut des sciences sociales de l'université de Lausanne ont mis en place une étude auprès de patients et de médecins généralistes sur l'accès aux profils génétiques de risque. L'attitude des médecins généralistes, objet de cet article, a été explorée par la méthode de consensus Delphi à deux tours. Cent vingt internes et chefs de clinique se sont prononcés sur 24 affirmations. Résultats : Un consensus a été obtenu pour 80 % des affirmations. Un rôle majeur des médecins généralistes se dessine autour de la démarche d'accès aux profils génétiques de risque, même si leur positionnement semble conditionné par leur place de professionnel de santé de première ligne, et que des doutes subsistent sur l'impact de cette démarche pour orienter leur pratique. Les besoins de formation sont largement soulignés ainsi qu'une possibilité de prise en charge pluridisciplinaire. La nécessité d'un encadrement législatif de ces pratiques fait consensus. Conclusion : Cette étude démontre la nécessité d'anticiper les besoins en développant un programme de formation et d'information pointu et évolutif pour les médecins généralistes dans le domaine de la médecine génomique, en vue d'activités de prévention qui pourraient en découler.

► **Cost-Effectiveness and Return on Investment of School-Based Health Promotion Programmes For Chronic Disease Prevention**

EKWARU J. P., OHINMAA A., DABRAVOLSKAJ J., *et al.*
2021

European Journal of Public Health.
<https://doi.org/10.1093/eurpub/ckab130>

While school-based health prevention programmes are effective in addressing unhealthy diet and physical inactivity, little is known about their economic implications. We conducted an economic evaluation of the programmes that were previously identified as feasible, acceptable, and sustainable in the Canadian context. This study builds on a meta-analysis of the effectiveness of feasible, acceptable, and sustainable school-based health promotion programmes. A micro-simulation model incorporated intervention effects on multiple risk factors to estimate incremental cost-effectiveness and return on investment (ROI) of comprehensive school health (CSH), multicomponent, and physical education (PE) curriculum modification programmes. Cost-effectiveness was expressed as the programme costs below which the programme would be cost-effective at a CA\$50 000 threshold level. The estimated costs below which interventions were cost-effective per quality-adjusted life year gained were CA\$682, CA\$444, and CA\$416 per student for CSH, multicomponent, and PE curriculum modification programmes, respectively. CSH programmes remained cost-effective per year of chronic disease prevented for costs of up to CA\$3384 per student, compared to CA\$1911 and CA\$1987 for multicomponent and PE curriculum modification interventions, respectively. If the interventions were implemented at total discounted intervention costs of CA\$100 per student, ROI through the avoidance of direct healthcare costs related to the treatment and management of chronic diseases would be 824% for CSH, 465% for multicomponent interventions, and 484% for PE curriculum modification interventions. Whereas each examined intervention types showed favourable economic benefits, CSH programmes appeared to be the most cost-effective and to have the highest ROI.

► **Sociodemographic Features and Patterns of Non-Participation in Colorectal Cancer Screening in Finland**

JÄNTTI M., HEINÄVAARA S., MALILA N., *et al.*
2021

European Journal of Public Health : ckab074.
<https://doi.org/10.1093/eurpub/ckab074>

Colorectal cancer (CRC) screening was run as a randomized health services programme in Finland between 2004 and 2016. This study evaluates sociodemographic features and patterns of non-participation among men and women invited to be screened. The study population in this register-based study includes 233 211 men and women invited to guaiac faecal occult blood test screening on consecutive screening rounds ($n = 708\,621$ invitations). A generalized estimating equation (GEE) was used to estimate incidence rate ratios (IRR) between sociodemographic features and non-participation. The overall proportion of non-participation was 31.6% and was higher in men (38.8%) than in women (24.6%). Birth cohort, education, marital status and country of birth were associated with non-participation. The birth cohort of 1950–54 was less likely to participate than the birth cohort of 1940–44. Men and women with primary education were more likely non-participants (IRR 1.26, CI 1.23–1.29 and IRR 1.22, CI 1.18–1.26, respectively) than men or women with tertiary education. Further, unmarried persons and immigrants had an increased risk of non-participation. Initial non-participation predicted subsequent behaviour, since, e.g. ~80% of first-round non-participants also remained non-participants in the second round. Education, gender and marital status had a significant effect on non-participation in the CRC screening programme. As high and comprehensive participation is essential for a successful screening programme, attention should be paid in ensuring participation of all sociodemographic groups. Special efforts should be invested in those not participating in the first invitation round, since initial non-participation predicts non-participation to subsequent invitations.

► **Shared Decision Making in Breast Cancer Screening Guidelines: A Systematic Review of Their Quality and Reporting**

MAES-CARBALLO M., MORENO-ASENCIO T., MARTÍN-DÍAZ M., *et al.*
2021

European Journal of Public Health : ckab084
<https://doi.org/10.1093/eurpub/ckab084>

Shared decision making (SDM) is a key component of evidence-based and patient-centred care. The aim of this study is to systematically review the quality of SDM proposals in clinical practice guidelines (CPGs) and consensus statements (CSs) concerning breast cancer (BC) screening. Guidances were identified, without language restrictions, using a prospectively planned systematic search (MEDLINE, EMBASE, Web of Science, Scopus and guideline websites) from January 2010 to August 2020. Duplicate data extraction used a 31-item SDM quality assessment tool; reviewer agreement was 98%. SDM appeared only in 38 (49.4%) (33/68 CPGs, 4/9 CSs) documents (overall compliance with the quality tool: mean 5.74, IQR 3–8). CPGs and CSs specifically mentioning the term SDM ($n = 12$) had higher quality (mean 6.8, IQR 4–9 vs. mean 2.1, IQR 0–3; $P = 0.001$). No differences were found in mean quality comparing CPGs with CSs (3 vs. 1.6; $P = 0.634$), use of systematic review (4.2 vs. 2.9; $P = 0.929$) and publication in a journal (4 vs. 1.9; $P = 0.094$). Guidances with SDM were more recently reported than those without it (mean 41 vs. 57 months; $P = 0.042$). More than half of all the guidelines did not meet SDM quality criteria. Those that explored it were more recently reported. There is an urgent need for promoting SDM in guidances concerning BC screening issued by institutions, professional associations and medical journals.

► **Le sport : nouvelle thérapeutique des maladies chroniques du XXI^e siècle**

MUELLER J. E.
2021

Actualité Et Dossier En Santé Publique(114): 12-49.
<https://www.hcsp.fr/Explore.cgi/adsp?clef=1175>

Les maladies chroniques sont la cause principale de décès dans le monde, avec un retentissement économique majeur. Le niveau de capacité physique est le meilleur reflet de notre capital santé, et représente un facteur de protection majeur souvent méconnu pour contrer le développement de ces pathologies. Récemment la mortalité liée au Covid-19 a révélé le rôle des comorbidités et notamment celui des maladies chroniques dont étaient atteintes un grand nombre de victimes. Selon l'OMS, un large pourcentage de maladies chroniques est accessible à la prévention par des actions sur quatre facteurs de risque : tabagisme, inactivité physique, consommation d'alcool et alimentation inadaptée. L'activité physique bien menée est toujours bénéfique en prévention primaire, secondaire ou tertiaire des maladies chroniques stables. Ce dossier présente les bénéfices de l'activité physique pour un grand nombre de maladies chroniques, y compris les pathologies mentales et la prévention de la dépendance lors du vieillissement. Une pratique régulière d'activité physique adaptée aux personnes atteintes d'une maladie chronique est indéniablement favorable à leur santé. Il s'agit de déterminer quel type d'activité, dans quel cadre et avec quel accompagnement.

Covid

► **Impact of an Interactive Web Tool on Patients' Intention to Receive COVID-19 Vaccination: A Before-And-After Impact Study Among Patients with Chronic Conditions in France**

TRAN V.-T., SIDORKIEWICZ S., PÉAN C., *et al.*
2021

BMC Medical Informatics and Decision Making
21(1): 228.

<https://doi.org/10.1186/s12911-021-01594-8>

In France, about 30% of the population refuses COVID-19 vaccination outright, and 9 to 40% are hesitant. We developed and evaluated an interactive web tool providing transparent and reliable information on the benefits and risks of COVID-19 vaccination.

► **Stratégie vaccinale contre la covid-19 au long terme : contrôle ou élimination ?**

MUELLER J. E.
2021

Actualité Et Dossier En Santé Publique(114): 5-9.

La vaccination permettra-t-elle d'éliminer l'épidémie de Covid ou de la contrôler ? Les résultats dépendront de l'efficacité vaccinale, de la durée de protection, de la sécurité des vaccins et de leur efficacité contre les variants. La première phase de riposte vaccinale à l'épidémie de Covid-19, avec des doses de vaccins disponibles limitées et en cours de déploiement, visait à la protection des personnes les plus à risque face à la Covid-19. Depuis, la couverture vaccinale s'est étendue à différentes catégories d'âge de personnes ou

professionnels de santé présentant des comorbidités. Ce choix de la Haute Autorité de santé cible préférentiellement la réduction de la mortalité, des hospitalisations et des formes graves. Mais une stratégie vaccinale à moyen et long termes doit être envisagée,

notamment pour réduire la circulation du SARS-CoV-2. Dès lors, quelle vision peut-on avoir pour la France : contrôle ou élimination de la Covid-19 ? Cet article présente une analyse des stratégies vaccinales nécessaires et des conditions de faisabilité

Prévision – Evaluation

Prevision - Evaluation

► **Leçons des évaluations d'impact sur la santé pour élaborer des politiques favorables à la santé**

CLAVIER C.
2021

Santé Publique 33(1): 5-6.

<https://www.cairn.info/revue-sante-publique-2021-1-page-5.htm>

Les évaluations d'impact sur la santé (EIS) ont été conçues pour contribuer à formuler des politiques publiques favorables à la santé physique, mentale et sociale en estimant les impacts positifs et négatifs d'une politique, d'un programme ou d'un projet sur les déterminants sociaux de la santé, l'état de santé des populations, le système de soins ou les inégalités sociales de santé. Réalisées de façon prospective, les EIS peuvent s'appliquer aussi bien aux grandes orientations des politiques gouvernementales ou locales (projet de loi ou de règlement), qu'à des modalités de leur mise en œuvre (programmes ou projets spécifiques). À quelles conditions peut-on espérer que cet instrument de la santé publique servira à orienter la formulation de politiques publiques plus justes, plus équitables et plus favorables à la santé et au bien-être de la population à tous les niveaux de gouvernance ?

► **L'évaluation d'impact sur la santé pour scruter et sculpter les politiques**

JABOT F.
2021

Santé Publique 33(1): 7-16.

<https://www.cairn.info/revue-sante-publique-2021-1-page-7.htm>

L'évaluation d'impact sur la santé (EIS) est une approche prospective qui consiste à identifier les conséquences potentielles, tant négatives que positives, d'une intervention sur la santé des populations dans le but de

l'améliorer. Identifiée comme pratique propre en 1999, elle a gagné rapidement en popularité et a été progressivement déployée sur tous les continents avec des déclinaisons diverses en termes de stratégies d'implantation, de domaines d'application, d'échelles de mise en œuvre, de modes de gouvernance, d'institutions et d'acteurs impliqués. Elle est actuellement en plein essor en France et au Québec où elle suscite de réelles attentes au regard des enjeux d'inégalités face à la santé, de démocratie et d'articulation des politiques sectorielles. Cet article, étayé sur nos travaux de recherche, brosse un rapide portrait de l'EIS en France et introduit un questionnement sur les atouts, les limites et la plus-value de la démarche. Le présent dossier apporte un éclairage sur la pratique à travers des applications dans différents domaines et contextes, met en relief les enjeux méthodologiques, politiques et sociaux ainsi que les défis à relever pour renforcer le potentiel de l'EIS à améliorer la décision et développer des politiques et projets favorables à la santé.

► **Similitudes et différences entre l'évaluation d'impact sur la santé et l'évaluation de politiques publiques**

JABOT F. ET MASSOT C.
2021

Santé Publique 33(1): 47-56.

<https://www.cairn.info/revue-sante-publique-2021-1-page-47.htm>

L'évaluation d'impact sur la santé (EIS) se développe rapidement en France. Elle est proche d'autres démarches, telles que l'évaluation de politiques publiques (EPP) avec laquelle elle est parfois confondue. Cet article a pour objectifs d'identifier les similitudes et différences entre EIS et EPP et d'apprécier dans quelle mesure les compétences en EPP sont transférables pour l'EIS. Les deux démarches présentent des

traits communs : elles sont basées sur des principes et valeurs structurant la pratique; elles produisent un jugement au terme d'un processus d'argumentation; elles suivent le même processus intellectuel et utilisent des outils similaires. Cependant, l'EIS présente des spécificités qui justifient le renforcement des compétences notamment en lien avec sa dimension participative. Les deux démarches présentent plus de similitudes que de différences en raison de leur nature évaluative. Les compétences acquises en EPP sont transférables à l'EIS et l'évaluateur à la croisée des deux exercices peut revisiter et enrichir sa pratique en EPP.

► **La participation citoyenne dans les évaluations d'impact sur la santé en France**

ROCOCO É., RIVADENEYRA-SICILIA A., ROSARIO B. D., *et al.*
2021

Santé Publique 33(1): 27-35.

<https://www.cairn.info/revue-sante-publique-2021-1-page-27.htm>

La participation citoyenne est l'une des valeurs clés de l'évaluation d'impact sur la santé (EIS). Cependant, un écart entre cet idéal affirmé dans les textes fon-

dateurs et la réalité est constaté dans la littérature. Compte tenu du développement de cette pratique en France, cet article propose un éclairage sur la compréhension du concept et les enjeux de sa mise en œuvre en France. La présente étude a été conduite sur un panel de 11 EIS réalisées dans huit régions entre 2011-2018 et fondée sur des entretiens, observations et analyse documentaire. La participation citoyenne est analysée selon cinq dimensions : perceptions et attentes des acteurs, étendue, intensité, modalités d'intervention, contraintes identifiées. La notion de « participation citoyenne » reste floue en France à l'instar des travaux conduits à l'étranger. Même si des progrès sont constatés dans les EIS les plus récentes, leur traduction concrète reste insuffisante en raison de contraintes politiques, financières et humaines et de la mise en concurrence avec les dispositifs participatifs existants. Bien que les acquis des expériences accumulées constituent des atouts pour une intégration effective de la participation, en vue de mieux ancrer l'EIS dans le système de valeurs de la promotion de la santé, cette étude met en avant l'importance de définir les objectifs de cette participation, de sensibiliser les élus en amont de la démarche, de renforcer les capacités des praticiens et d'avoir recours à des spécialistes du domaine de la participation.

Psychiatrie

Psychiatry

► **Psychiatrie et soins somatiques « C'est pas le tout d'y dire, faut aussi y faire »**

ANASTASI A.
2021

L'information psychiatrique 97(6): 465-475.

<https://www.cairn.info/revue-l-information-psychiatrique-2021-6-page-465.htm>

Les patients psychiatriques ont une espérance de vie réduite du fait d'une morbi-mortalité somatique augmentée. Les difficultés d'accès aux soins en sont les causes essentielles malgré une évolution de la prise en compte de ces problématiques au cours des dernières années. La prise en charge des patients psychiatriques doit être globale et s'appuyer sur des dispositifs allant du droit commun à des structures hospitalières spécialisées comme les unités médico-psychiatriques, en

capacité d'appréhender simultanément des situations somato-psychiatriques complexes. L'unité de médecine du centre hospitalier Le Vinatier illustre ce type de prises en charge. La temporalité nécessaire au soin de ces patients est un paramètre incontournable de ce type de situations complexes. Les unités médico-psychiatriques sont complémentaires dans le parcours de soins global pensé autour du sujet psychiatrique et restent concurrentielles au vu du service médical rendu à une population de patients vulnérables.

► **Psychiatrie : la réforme des isolements et contentions a du mal à passer**

BOULANGER F.
2021

Cahiers De Santé Publique Et De Protection Sociale (Les)(37): 2.

<https://cahiersdesante.fr/editions/psychiatrie-la-reforme-des-isolements-et-contentions-a-du-mal-a-passer/?print-posts=pdf>

Les réformes sécuritaires de la psychiatrie conduisent à une augmentation des mesures d'isolement des malades et de contention. Ceci ne fait pas baisser la violence dans les services. La diminution de la violence ne se décrète pas par une loi, mais par une vraie politique en faveur du soin. Par une politique qui se donne les moyens de son ambition en recrutant et en formant des professionnels de santé.

► **La psychiatrie façon puzzle**

CHAPIREAU F.
2021

L'information psychiatrique 97(6): 445-446.

<https://www.cairn.info/revue-l-information-psychiatrique-2021-6-page-445.htm>

Une contradiction fondamentale qui traverse nos systèmes d'aide et de soins est spécialement à l'œuvre dans la psychiatrie de service public : deux politiques s'y superposent sans se concilier. L'une porte sur la spécialisation des soins, l'autre sur leur continuité. Comment dépasser ce dilemme ? Depuis les « lois Debré » de 1958, les réformes du système de santé y impulsent une spécialisation et donc une diversification croissantes. De même, les dispositifs d'aide sociale et médicosociale visent de plus en plus de groupes cibles. Dans tous les cas, chaque personne est définie par des caractéristiques précises qui lui permettent de bénéficier d'une prestation, d'un service ou d'un établissement ; cela s'appelle l'adéquation. Depuis quelques années, sous l'influence notamment des associations d'utilisateurs, on s'aperçoit que les politiques d'adéquation ont construit un « labyrinthe », une « myriade de structures » peu ou pas articulées entre elles.

► **Stakeholders' Views on Online Interventions to Prevent Common Mental Health Disorders in Adults Implemented into Existing Healthcare Systems in Europe**

KUSO S., NITSCH M., ZEILER M., *et al.*
2021

European Journal of Public Health 31(Supplement_1): i55-i63.

<https://doi.org/10.1093/eurpub/ckab043>

Online preventive interventions can help to reduce the incidence of mental disorders. Whereas knowledge on stakeholders' attitudes and factors relevant for successfully integrating online treatment into existing healthcare systems is available, knowledge is scarce for online prevention. Stakeholders from Germany, Switzerland, Austria and Spain were surveyed. Potential facilitators/delivery staff (e.g. psychologists, psychotherapists) completed an online questionnaire (n = 183), policy makers (i.e. from the governing sector or health insurance providers) participated in semi-structured interviews (n = 16) and target groups/potential users of mental illness prevention (n = 49) participated in ten focus groups. Thematic analysis was used to identify their experiences with and attitudes and needs regarding online programmes to prevent mental disorders. Additionally, it was examined which groups they consider underserved and which factors they consider as fostering and hindering for reach, adoption, implementation and maintenance (cf. RE-AIM model) when integrating online prevention into existing healthcare systems. Main advantages of online mental illness prevention are perceived in low structural and psychological barriers. Lack of personal contact, security, privacy and trust concerns were discussed as disadvantages. Relevant needs are high usability and target group appropriateness, evidence for effectiveness and the use of motivational tools. Positive attitudes among stakeholders are the key for successful integration of online mental illness prevention into existing healthcare systems. Potential facilitators/delivery staff must receive training and support to implement these programmes; the programmes must be attractive and continuously evaluated, updated and promoted to ensure ongoing reach; and existing infrastructure and contextual factors must be considered.

► **Multiplication des dispositifs de remboursement : quid du psychologue ?**

MONDIÈRE G.
2021

Le Journal des psychologues 389(7): 8-10.

<https://www.cairn.info/revue-le-journal-des-psychologues-2021-7-page-8.htm>

Depuis la fin des années 2010, les dispositifs s'accumulent sans aucune réflexion prospective sur une articulation cohérente entre les besoins de la population et les compétences des psychologues. En France, dans un système de santé essentiellement médico-centré et orienté davantage vers la guérison que la prévention, penser la place des psychologues ne va pas de soi. L'apparition des psychologues dans les rapports de psychiatrie date des années 2000. En 2001, le rapport Piel / Roelandt précise le nombre de psychologues qui s'élèverait alors « à près de 36 000 personnes salariées ou libérales... Selon la Statistique annuelle des établissements (SAE), on compte alors environ 4 000 psychologues ETP – soit seulement 1

pour 15 infirmiers – dans des services de psychiatrie des établissements de santé.

► **Economics of Mental Well-Being: A Prospective Study Estimating Associated Health Care Costs and Sickness Benefit Transfers in Denmark**

SANTINI Z. I., BECHER H., JØRGENSEN M. B., *et al.*
2021

The European Journal of Health Economics 22(7): 1053-1065.

<https://doi.org/10.1007/s10198-021-01305-0>

Previous literature has examined the societal costs of mental illness, but few studies have estimated the costs associated with mental well-being. In this study, a prospective analysis was conducted on Danish data to determine 1) the association between mental well-being (measured in 2016) and government expenditure in 2017, specifically healthcare costs and sickness benefit transfers.

Covid

► **Les habitats collectifs et accompagnés en santé mentale à l'épreuve de la pandémie de Covid-19 : entre protection vis-à-vis du virus et soutien à l'autonomie**

LE HELLEY M., RAPEGNO N. ET ROSENFELDER C.
2021

Revue française des affaires sociales(2): 57-75.

<https://www.cairn.info/revue-francaise-des-affaires-sociales-2021-2-page-57.htm>

Cet article propose de donner à voir la gestion de crise de Covid-19 dans quatre habitats collectifs et accompagnés en santé mentale. Il repose sur l'analyse d'entretiens réguliers réalisés avec des professionnels de ces lieux de vie, de mars 2020 à juin 2020. Les habitats ont suivi les directives destinées aux établissements médico-sociaux, cherchant un cadre de référence pour protéger les locataires du virus. Pendant le confinement, les accompagnements habituellement proposés dans ces habitats (et qui sont majoritairement pensés pour favoriser l'autonomie dans la vie quotidienne) ont été réduits et recentrés sur le maintien du lien avec les locataires et sur des actions de prévention. Le déconfinement a été placé sous le signe de la prudence et s'est effectué de manière progressive. Les professionnels,

confrontés à de nouvelles épreuves et à de nouveaux dilemmes pour concilier les principes de protection et d'autonomie, ont dû redéfinir leurs pratiques.

► **Mental Health Inequalities Increase As a Function of COVID-19 Pandemic Severity Levels**

MAFFLY-KIPP J., EISENBECK N., CARRENO D. F., *et al.*
2021

Social Science & Medicine 285: 114275.

<https://doi.org/10.1016/j.socscimed.2021.114275>

Rationale Current evidence suggests that mental health across the globe has suffered significantly during the COVID-19 global pandemic, and that disadvantaged communities are suffering these impacts more acutely. Lower income, female gender, and younger age have all been associated with worse psychopathology during COVID-19. Objective and methods The goal of this study was to determine whether these disparities are more pronounced in places where the pandemic is more severe. We analyzed self-report data and objective metrics from a large global sample (N = 11,227) in order to test the hypothesis that

country-level severity of COVID-19 moderates the relationship between the target demographic variables (Subjective SES, gender and age) and psychopathology indicators. Results Severity of the pandemic emerged as a significant moderator of the relationship between these demographic variables and mental health outcomes. This pattern was extremely consistent for Subjective SES and gender, but slightly more nuanced for age. Conclusion Overall, we interpreted our data as suggesting that mental health disparities are greater in countries with more severe COVID-19 outbreaks. These findings are critical for understanding the ways that the ongoing pandemic is affecting global mental health, and contribute to the broader literature surrounding collective trauma.

► **Changes in Psychological Distress Before and During the COVID-19 Pandemic Among Older Adults: The Contribution of Frailty Transitions and Multimorbidity**

WANG Y., FU P., LI J., *et al.*
2021

[Age and Ageing 50\(4\): 1011-1018.](https://doi.org/10.1093/ageing/afab061)
<https://doi.org/10.1093/ageing/afab061>

The aim of this study was to investigate changes in psychological distress in community-dwelling older adults before and during the coronavirus disease 2019 (COVID-19) pandemic and the contribution of frailty transitions and multimorbidity in predicting the psy-

chological distress. Prospective repeated-measures cohort study on a sample of participants aged 60 and over. A total of 2,785 respondents at the baseline (May 2019) were followed during the COVID-19 (August 2020). The changes in psychological distress before and during the COVID-19 were assessed using generalised estimation equations with adjusting for sex, age, education, economic status, marital status, tea drinking status, smoking status, alcohol drinking status, sedentary time, sleep quality and activities of daily living. The psychological distress of older people has significantly increased in August 2020 compared with May 2019. Both older adults who remained frail and transitioned into frail state reported more psychological distress during the COVID-19. Similarly, both pre-existing multimorbidity and emerging multimorbidity groups were associated with more psychological distress. The group of frailty progression who reported new emerging multimorbidity showed more increase in psychological distress in comparison with those who remained in the non-frail state who reported no multimorbidity. Psychological distress has increased among the community-dwelling older adults during the COVID-19 pandemic, and sustained and progressive frail states as well as multimorbidity were all associated with a greater increase of psychological distress. These findings suggest that future public health measures should take into account the increased psychological distress among older people during the COVID-19 pandemic, and the assessment of frailty and multimorbidity might help in warning of psychological distress.

Information Sciences

Sciences de l'information

► **Publishing and Flourishing: Writing For Desire in Higher Education**

HERON M., GRAVETT K. ET YAKOVCHUK N.
2021

[Higher Education Research & Development 40\(3\): 538-551.](https://doi.org/10.1080/07294360.2020.1773770)
<https://doi.org/10.1080/07294360.2020.1773770>

In the current performative climate of higher education, where academic outputs are highly valorised, professional academic writing has become « high stakes » and is often framed as fraught with tension and anxiety.

In this article, we contest the phrase « publish or perish » and argue that is not necessarily helpful or, indeed, always true. Through interviews involving critical incidents with a team of academics, the authors found that tensions in experiences of scholarly writing do indeed exist. However, participants also reported on the affordances of the process of professional academic writing in terms of developing ideas, collaborations, and creating spaces for creativity and desire. We emphasise the juxtaposition of the value of creation with the value of the finished product and argue that writing for publication needs to be highlighted

as a process permeated with learning opportunities for both early career researchers and more experienced academics.

► **Comment faire une revue non systématique de la littérature ?**

HOARAU D., MICHEL P. ET LEBLANC P.
2021

Risques & Qualité En Milieu De Soins 18(1).

<https://www.hygienes.net/boutique/risques-qualite/comment-faire-une-revue-non-systematique-de-la-litterature>

Une revue de la littérature est un exercice visant à récupérer et à ordonner des articles, ouvrages ou documents de la littérature scientifique. Il ne s'agit pas de simplement lister ou énumérer les articles les uns à la suite des autres, mais d'agencer ces travaux selon une certaine perspective. Une revue de la littérature permet ainsi de faire la synthèse des connaissances sur un sujet, ainsi que d'en définir les limites, dans le but d'identifier de nouvelles pistes de réflexions ou de travail. Cette revue de la littérature peut donc servir un projet de recherche ou la mise en place d'une démarche d'amélioration de la qualité. Ce travail, qui est consommateur de temps et de ressources mérite lorsqu'il est rigoureusement mené d'être partagé. Cet article présente trois types de revue non systématiques de la littérature : revue narrative, scoping review, mapping review.

► **Stakeholder Involvement in Systematic Reviews: Lessons From Cochrane's Public Health and Health Systems Network**

MERNER B., LOWE D., WALSH L., *et al.*
2021

American Journal of Public Health 111(7): 1210-1215.

<https://doi.org/10.2105/AJPH.2021.306252>

Translating evidence, including evidence from systematic reviews, into policy and practice is a major challenge for evidence producers. Stakeholder involvement in how reviews are prioritized, produced, and disseminated may improve their relevance and translation into policy and practice. Stakeholder involvement is continuing to grow, with a 2018 scoping review identifying nearly 300 examples in the field of systematic reviews. However, many reported too few details for replication, thus limiting evidence to inform recommendations for future practice. In Cochrane Reviews, as in other types of health research, stakeholder involvement has taken different forms and involved a range of methods. Levels of involvement within and across reviews can also vary, as categorized by the ACTIVE (Authors and Consumers Together Impacting on evidence) framework. According to ACTIVE, involvement may fall on a continuum.

Sociologie de la santé

Sociology of Health

► **Faire de la médecine et de la santé un objet de sociologie générale**

2021

Actes de la recherche en sciences sociales 239(4): 10-19.

<https://www.cairn.info/revue-actes-de-la-recherche-en-sciences-sociales-2021-4-page-10.htm>

La trajectoire du sociologue Patrice Pinell donne à voir l'histoire d'un courant de sociologie critique. Formé à la médecine puis à la biochimie dans les années 1960, il entre à l'Institut national de la santé et de la recherche

médicale (Inserm) au début des années 1970. Sa conversion à la sociologie est liée à ses engagements politiques et syndicaux et à des rencontres, en particulier avec trois sociologues : Jacques Maître, venu de la sociologie des religions (il fut l'un des membres fondateurs du Groupe de sociologie des religions) à celle de la santé, dans une approche marquée par la psychanalyse, puis Pierre Bourdieu, à l'École pratique des hautes études, et enfin Claudine Herzlich, qui a particulièrement œuvré à l'introduction des sciences sociales au sein de l'Inserm au début des années 1980. Contre un usage de la sociologie et de l'histoire comme disciplines annexes de l'épidémiologie et de la santé

publique, il fait de la santé et de la médecine des objets de sociologie générale en développant une analyse socio-historique du champ médical.

► **On the Effect of Uncertainty on Personal Vaccination Decisions**

COURBAGE C. ET PETER R.
2021

Health Economics : Ahead of pub.

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4405>

This study investigates the effect of ambiguity on personal vaccination decisions. We first characterize the vaccination decision in the absence of ambiguity. We then show that uncertainty about the probability of side effects and the efficacy of the vaccine always reduces take-up under ambiguity aversion. However, uncertainty about the underlying disease, being the probability of sickness or the probability of a severe course of disease, may either encourage or discourage vaccination. Our results are relevant for policy because reducing uncertainty associated with the vaccine always has the desired effect whereas reducing uncertainty associated with the disease may have unintended consequences.

► **La santé publique comme objet sociologique. Trajectoires de recherche, productions scientifiques et configurations institutionnelles**

GELLY M., MARIETTE A. ET PITTI L.
2021

Actes de la recherche en sciences sociales 239(4): 4-9.

<https://www.cairn.info/revue-actes-de-la-recherche-en-sciences-sociales-2021-4-page-4.htm>

Tout en maniant des paradigmes différents d'analyse, les trois sociologues que nous avons interviewé-e-s dans le cadre de ce dossier témoignent des enjeux de l'autonomie d'une recherche sociologique qui se donne la santé – et notamment la santé publique – pour objet. Le premier entretien permet de revenir sur l'histoire d'un courant de sociologie critique à travers la trajectoire de Patrice Pinell. Formé à la médecine puis à la biochimie dans les années 1960 avant de se convertir à la sociologie et de diriger, pendant plus de dix ans, une unité de recherches psychanalytiques et sociologiques en santé publique au sein de l'Inserm, ce dernier fait de la santé et de la médecine des objets

de sociologie générale et critique, en développant une analyse socio-historique du champ médical. Le second entretien interroge les enjeux des recherches sociologiques sur la santé dans des mondes professionnels et des institutions de santé publique, à partir de deux trajectoires professionnelles et scientifiques : celle de Cécile Fournier, chercheuse à l'Institut de recherche et documentation en économie de la santé (Irdes), et celle de Gabriel Girard, chargé de recherche à l'Institut national de la santé et de la recherche médicale (Inserm) après un parcours dans le domaine de la santé publique au Québec.

► **Venir à la sociologie par la santé publique, faire de la santé publique en sociologue**

GIRARD G.
2021

Actes de la recherche en sciences sociales 239(4): 20-29.

<https://www.cairn.info/revue-actes-de-la-recherche-en-sciences-sociales-2021-4-page-20.htm>

Cet entretien interroge les enjeux des recherches sociologiques sur la santé dans des mondes professionnels et des institutions de santé publique, à partir de deux trajectoires professionnelles et scientifiques : celle de Cécile Fournier, chercheuse à l'Institut de recherche et documentation en économie de la santé (Irdes), et celle de Gabriel Girard, chargé de recherche à l'Institut national de la santé et de la recherche médicale (Inserm) après un parcours dans le domaine de la santé publique au Québec.

► **Préférences et perceptions face au risque : quels enseignements pour des applications à la santé ?**

L'HARIDON O. ET SEROR V.
2021

Revue française d'économie XXXVI(1): 15-56.

<https://www.cairn.info/revue-francaise-d-economie-2021-1-page-15.htm>

Cet article présente un état de l'art des avancées théoriques et méthodologiques en économie comportementale à des fins d'économie appliquée. Il s'intéresse notamment aux enjeux de santé. Partant du modèle d'utilité espérée, modèle normatif de choix rationnel, largement développé et utilisé au 20ème siècle, nous présentons en quoi l'économie comportementale, d'une part, et la psychologie cognitive d'autre part,

ont permis d'enrichir cette analyse traditionnelle de la prise de risque individuelle. En particulier, nous recherchons de quelle manière l'économie comportementale rend compte de manière plus approfondie de la subjectivité du risque au travers d'une vision plus générale de la « chance ». Nous illustrons notre propos grâce à la mesure empirique de ces modèles d'économie comportementale, appliqués notamment aux enjeux de santé. En séparant les rôles respectifs des utilités associées aux conséquences, de l'éventuelle transformation des probabilités et des jugements probabilistes, de telles approches apparaissent particulièrement adaptées à des contextes où prévalent des incertitudes individuelles et collectives quant à la santé et l'économie. Nous envisageons enfin dans quelle mesure toute une littérature classique en psychologie cognitive sur la perception de l'incertitude éclaire l'économiste sur la complexité de la formation des croyances, notamment en matière de santé.

► **Patients' Free Choice of Physicians Is Not Always Good**

LI X. ET WAIBEL C.
2021

Health Economics n/a(n/a).

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4407>

Abstract We present a model of learning in healthcare markets. Hospitals have junior physicians with low and senior physicians with high ability. Junior physicians turn senior if they treat enough patients. Patients face heterogeneous costs for waiting if a physician's capacity is utilized. Hospitals choose to either allocate patients to physicians randomly or let patients choose their physicians. In a monopolistic market, the hospital always chooses the welfare-maximizing allocation system. In a competitive market, inefficiencies may arise due to two externalities. If patients are free to choose their physician, the marginal patient neither internalizes her impact on other patients' waiting costs nor the learning of junior physicians.

► **How Do People Understand Overtesting and Overdiagnosis? Systematic Review and Meta-Synthesis of Qualitative Research**

ROZBROJ T., HAAS R., O'CONNOR D., *et al.*
2021

Social Science & Medicine 285: 114255.

<https://doi.org/10.1016/j.socscimed.2021.114255>

The public should be informed about overtesting and overdiagnosis. Diverse qualitative studies have examined public understandings of this information. A synthesis was needed to systematise the body of evidence and yield new, generalisable insights. Aim Synthesise data from qualitative studies exploring patient and public understanding of overtesting and overdiagnosis. We searched Scopus, CINAHL, Ovid MEDLINE and PsycINFO databases from inception to March 18, 2020. Only qualitative parts of mixed-methods studies were synthesised. We synthesised data from 21 studies, comprising 1638 participants, from 2754 unique records identified. We identified six descriptive themes, all graded as moderate confidence (indicating they are likely to reasonably represent the available evidence): i) high confidence in screening and testing; ii) difficulty in understanding overuse; iii) acceptance that overuse can be harmful; iv) rejection or problematisation of overuse; v) limited impacts of overuse information on intended test and screening uptake; vi) desire for information and shared decision-making regarding overuse. The descriptive themes were underpinned by two analytic themes: i) perceived intrinsic value of information and information gathering, and; ii) differences in comprehension and acceptance of overuse concepts. Conclusions This study identified novel and important insights about how lay people interpret overuse concepts. It will guide the development of more effective public messages about overuse, highlighting the importance of interpretative frameworks in these communications.

Covid

► **« L'épidémie » de plaintes en temps de Covid-19 : en France, en Espagne et en Belgique**

BAILLY J.
2021

[Revue française des affaires sociales\(2\): 37-56.](https://www.cairn.info/revue-francaise-des-affaires-sociales-2021-2-page-37.htm)

<https://www.cairn.info/revue-francaise-des-affaires-sociales-2021-2-page-37.htm>

La « crise sanitaire » liée à la propagation du Covid-19 (étudiée ici entre mars et juin 2020) a été marquée par un ensemble varié de recours en justice, qui peuvent paraître inédits au regard de la sociologie du droit. En prenant pour cadre de comparaison la France, l'Espagne et la Belgique, cet article interroge la portée symbolique et politique des plaintes au regard des contributions des sociologies américaine et française du droit. Il s'agit autant de rendre intelligible « l'épidémie » des recours en justice que d'explorer les manières dont elles questionnent les légitimités politiques attachées à la gestion politico-administrative de la « crise » et à l'économie politique plus généralement, qui affecte la régulation publique du domaine sanitaire.

► **Public Attitudes Toward Pandemic Triage: Evidence From Conjoint Survey Experiments in Switzerland**

KNOTZ C. M., GANDENBERGER M. K., FOSSATI F., *et al.*
2021

[Social Science & Medicine 285: 114238.](https://doi.org/10.1016/j.socscimed.2021.114238)

<https://doi.org/10.1016/j.socscimed.2021.114238>

The question of how to implement medical triages has become highly salient during the COVID-19 pandemic and continues to be actively discussed. It is important to know how members of the general public think about this issue. For one, knowledge about the public's standpoint can help resolve important questions where ethical considerations are by themselves not sufficient, for instance whether the patient's age should matter. It can also help identify if more communication with the public about medical ethics is needed. We study how members of the Swiss public would allocate intensive medical care among COVID-19 patients using data from two original conjoint survey experiments conducted in Switzerland in the context of the first and second pandemic waves in 2020 (N = 1457 & N = 1450). We find that our participants would not base triage decisions on the patient's age. However, they do give much importance to the patient's behavior prior and during illness, discriminate against non-nationals, and assign only a relatively small and inconsistent role to medical considerations. Our findings suggest that there is a need for more communication with the public about the ethics of medical triage.

Soins de santé primaires

Primary health Care

► **Who Cares when You Close Down? the Effects of Primary Care Practice Closures on Patients**

BISCHOF T. ET KAISER B.
2021

[Health Economics 30\(9\): 2004-2025.](https://onlinelibrary.wiley.com/doi/abs/10.1002/heal.4287)

<https://onlinelibrary.wiley.com/doi/abs/10.1002/heal.4287>

This paper investigates the consequences that patients face when their regular general practitioner (GP) closes down her practice, typically due to retirement. We estimate the causal impact of closures on patients' utilization patterns, healthcare expenditures, hospitalizations, mortality, and health plan choices. Employing a difference-in-difference framework, we find that patients who experience a discontinuity of care per-

sistently adjust their ambulatory utilization pattern by shifting visits away from GPs (-12%) toward specialists (+11%) and hospital outpatient facilities (+6%). In contrast, we find no evidence on adverse health effects as measured by hospitalizations and mortality. The impact on utilization is heterogeneous along several dimensions. In particular, we find geographic disparities between regions with high and low availability of primary care. We also observe that patients with chronic conditions substitute more strongly toward other providers. Our results have potential implications for health policy in at least two dimensions: first, practice closures lead to more fragmented care which may entail inefficiencies, and second, closures deteriorate access to primary care in regions with low physician density.

► **Clinical Medication Review in French Community Pharmacy: Interest of a New Pharmaceutical Service For Detection of Drug Related Problems**

BONNAN D., AMOUROUX F. ET AULOIS-GRIOT M.
2021

Ann Pharm Fr 79(5): 597-603.

Using clinical medication reviews, analyze the most pharmaceuticals intervention generating treatments and the problems associated. Analysis of activity reports made by 6th year pharmaceutical students from the University of Bordeaux, class of 2017-2018. 76 % of clinical medication review have detected at least one drug related problem in the population of this study. Drug classes that most frequently lead to pharmaceutical interventions are nervous system drugs, alimentary tract and metabolism drugs and cardiovascular system drugs. The most frequent drug related problems are an unjustified prescription, a contraindication or a non-compliance with the standards of care and posology issues. The most at risk and pharmaceutical intervention generating drugs in this study are the same as described in the international literature. This shows that more precautions must be taken for their use in the elderly. Furthermore, this new pharmaceutical service is an efficient way to detect them.

► **D'un SAU à une maison de santé : un exemple de circuit de réorientation**

COSME E., CURATOLO N., TITOMANLIO L., *et al.*
2021

Gestions hospitalières(606): 297-301.

L'organisation de la prise en charge des urgences est une problématique majeure du système de santé français, confrontée notamment à un lien défaillant entre les urgences hospitalières et la médecine de ville. En découle une augmentation constante du nombre de passage aux urgences. Certains pays ont introduit des incitations financières pour diminuer ce recours trop fréquent aux urgences. La réorientation vers un cabinet médical, une maison de santé, une maison médicale de garde est une autre solution adoptée par différents pays : Allemagne, Belgique, Royaume-Uni, Etats-Unis et Canada.

► **Préfigurer l'exercice de la pratique infirmière avancée : une coconstruction à l'œuvre en milieu de soins**

DE ROSIS C., TEIXEIRA M. ET JOVIC L.
2021

Santé Publique 33(1): 89-100.

<https://www.cairn.info/revue-sante-publique-2021-1-page-89.htm>

La fonction d'infirmière en pratique avancée (IPA) fait l'objet d'un nombre croissant de recherches. Peu nombreuses sont celles ayant analysé les processus locaux de son implantation. Celle présentée dans cet article porte sur une expérimentation préfigurant la fonction d'IPA (pré-IPA) dans le système de soins français. Cette étude examine les obstacles et les leviers au développement de la fonction des pré-IPA à la lumière de leur rôle actif dans les processus de leur implantation. Parmi les freins figurent des confusions de la fonction des pré-IPA avec d'autres fonctions infirmières de la part de leurs collègues et supérieurs hiérarchiques, des assimilations partielles à la profession médicale, la restriction de l'exercice des pré-IPA sous l'effet du contrôle des médecins au sein de relations interprofessionnelles très ambivalentes. Les médecins ont aussi joué un rôle de levier dans le cadre d'un mentorat interprofessionnel visant à promouvoir l'introduction des pré-IPA. Celles-ci ont adopté des stratégies de négociation de leurs compétences, d'information et de sensibilisation sur leur fonction tout en revendiquant une identité professionnelle se construisant sur leur compétence d'infirmière experte dans les soins

infirmiers de leur domaine d'exercice (le sujet âgé, la santé mentale et la psychiatrie, l'accompagnement des patients chroniques ou atteints de cancer, les soins de premiers recours). Conclusion : Le développement de la pratique infirmière avancée ne peut dériver que partiellement des structures formelles et des cadres réglementaires. Les diverses initiatives pour faire connaître, construire et installer ces fonctions sont illustratives d'un processus de coconstruction dans les milieux d'exercice.

► **Understanding Physicians' Perceptions of Overuse of Health Services in Oncology**

ELLEN M., PERLMAN S., HOROWITZ E., *et al.*
2021

Medical Care Research and Review 78(5): 511-520.

<https://journals.sagepub.com/doi/abs/10.1177/1077558720915112>

Overuse rates in oncology are high, but areas of possible improvement exist for reducing it and improving quality of care. This study explores perceptions and experiences of oncologists in Israel regarding overuse of health services within oncology. In-depth, semistructured interviews were conducted focusing on causes of overuse, facilitators for reduction, and suggestions for improvement. Interviews were audio recorded, transcribed, coded, and thematically analyzed. Physicians reported patient-level causes including "well-informed" and "demanding" patients; physician-level causes including desire to satisfy patients, lack of confidence, time, and skills; and system-level causes like ease of access, and lack of alignment and coordination. Physicians can reduce overuse through patient dialogue, building trust and solidifying patient-physician relationships, and further reduce overuse with better teamwork. Improvements can be made through educational initiatives, and bottom-up solutions. Policy makers and decision makers should develop appropriate interventions addressing health service overuse, including improving patient education and instilling confidence and knowledge in physicians.

► **Evaluating the Effectiveness of a Local Primary Care Incentive Scheme: A Difference-In-Differences Study**

KHEDMATI MORASAE E., ROSE T. C., GABBAY M., *et al.*

2021

Medical Care Research and Review : Ahead of pub.

<https://journals.sagepub.com/doi/abs/10.1177/10775587211035280>

National financial incentive schemes for improving the quality of primary care have come under criticism in the United Kingdom, leading to calls for localized alternatives. This study investigated whether a local general practice incentive-based quality improvement scheme launched in 2011 in a city in the North West of England was associated with a reduction in all-cause emergency hospital admissions. Difference-in-differences analysis was used to compare the change in emergency admission rates in the intervention city, to the change in a matched comparison population. Emergency admissions rates fell by 19 per 1,000 people in the years following the intervention (95% confidence interval [17, 21]) in the intervention city, relative to the comparison population. This effect was greater among more disadvantaged populations, narrowing socio-economic inequalities in emergency admissions. The findings suggest that similar approaches could be an effective component of strategies to reduce unplanned hospital admissions elsewhere.

► **The Pros and Cons of the Implementation of a Chronic Care Model in European Rural Primary Care: The Points of View of European Rural General Practitioners**

KURPAS D., PETRAZZUOLI F., SZWAMEL K., *et al.*
2021

Rural Remote Health 21(3): 6509.

This article describes the views of European rural general practitioners regarding the strengths, weaknesses, opportunities and threats (SWOT) of the implementation of a chronic care model (CCM) in European rural primary care. This was a mixed-methods online survey. Data were collected from 227 general practitioners between May and December 2017. Categorical data were analysed using descriptive methods while free-text responses were analysed using qualitative methods. The setting was rural primary care in nine European countries (including Central and Eastern Europe). Main outcomes measures were respondents' evaluations of

a chronic care model in their rural healthcare settings in terms of SWOT. The SWOT analysis showed that the expertise of healthcare professionals and the strength of relationships and communications between professionals, caregivers and patients are positive components of the CCM system. However, ensuring adequate staffing levels and staff competency are issues that would need to be addressed. Opportunities included the need to enable patients to participate in decision making by ensuring adequate health literacy. The CCM could certainly have benefits for health care in rural settings but staffing levels and staff competency would need to be addressed before implementation of CCM in such settings. Improving health literacy among patients and their carers will be essential to ensure their full participation in the implementation of a successful CCM.

► **Achieving Higher Performing Primary Care Through Patient Registration: A Review of Twelve High-Income Countries**

MARCHILDON G., BRAMMLI-GREENBERG S., DAYAN M., *et al.*
2021

Health Policy : Ahead of pub.

<https://doi.org/10.1016/j.healthpol.2021.09.001>

Patient registration with a primary care providers supports continuity in the patient-provider relationship. This paper develops a framework for analysing the characteristics of patient registration across countries; applies this framework to a selection of countries; and identifies challenges and ongoing reform efforts. Methods 12 jurisdictions (Denmark, France, Germany, Ireland, Israel, Italy, Netherlands, Norway, Ontario [Canada], Sweden, Switzerland, United Kingdom) were selected for analysis. Information was collected by national researchers who reviewed relevant literature and policy documents to report on the establishment and evolution of patient registration, the requirements and benefits for patients, providers and payers, and its connection to primary care reforms. Results Patient registration emerged as part of major macro-level health reforms linked to the introduction of universal health coverage. Recent reforms introduced registration with the aim of improving quality through better coordination and efficiency through reductions in unnecessary referrals. Patient registration is mandatory only in three countries. Several countries achieve high levels of registration by using strong incentives

for patients and physicians (capitation payments). Conclusion Patient registration means different things in different countries and policy-makers and researchers need to take into consideration: the history and characteristics of the registration system; the use of incentives for patients and providers; and the potential for more explicit use of patient-provider agreements as a policy to achieve more timely, appropriate, continuous and integrated care.

► **Intégration des infirmières praticiennes en soins de santé primaires : repenser la négociation de dynamiques complexes**

RIOUX-DUBOIS A. ET PERRON A.
2021

Recherche en soins infirmiers 145(2): 38-52.

<https://www.cairn.info/revue-recherche-en-soins-infirmiers-2021-2-page-38.htm>

L'intégration des infirmières praticiennes en soins de santé primaires est hautement complexe mais peu étudiée au regard de changements socioprofessionnels plus larges dans le système de santé. Le but de cette étude était d'examiner l'intégration et la négociation du rôle des infirmières praticiennes en contexte interprofessionnel dans divers modèles de soins de santé primaires. Une ethnographie multisite critique, combinant la théorie de l'acteur-réseau et les concepts foucauldien de discours et pouvoir, a été menée au sein de trois différents modèles de soins dans lesquels des entrevues semi-dirigées (n=23 infirmières praticiennes), de l'observation directe et de l'analyse documentaire ont été réalisées. Les finalités organisationnelles, les normes de pratique, le droit des infirmières praticiennes à l'autodétermination, les dynamiques de collaboration avec les médecins, ainsi que la prise en charge des patients ont été identifiés comme des facteurs d'intégration produisant davantage d'instabilités, de négociations et de contrecoups professionnels, identitaires et moraux chez ces professionnelles. Ces résultats remettent en question la perception répandue d'un manque de clarté du rôle des infirmières praticiennes et permettent une compréhension renouvelée de leur intégration en soins de santé primaires.

► **Duration of Medical Home Participation and Quality of Care For Patients with Chronic Conditions**

SWIETEK K. E., DOMINO M. E., GROVE L. R., *et al.*
2021

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

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13710>

The objective of this paper is to examine whether the length of participation in a patient-centered medical home (PCMH), an evidence-based practice, leads to higher quality care for Medicaid enrollees with multiple co-morbid chronic conditions and major depressive disorder (MDD). **Data Sources** This analysis uses a unique data source that links North Carolina Medicaid claims and enrollment data with other administrative data including electronic records of state-funded mental health services, a state psychiatric hospital utilization database, and electronic records from a five-county behavioral health carve-out program. **Study Design** This retrospective cohort study uses generalized estimating equations (GEEs) on person-year-level observations to examine the association between the duration of PCMH participation and measures of guideline-concordant care, including the receipt of minimally adequate care for MDD, defined as 6 months of antidepressant use or eight psychotherapy visits each year. **Data Collection/Extraction Methods** Adults with two or more chronic conditions reflected in administrative data, including MDD. **Principal Findings** We found a 1.7 percentage point increase in the likelihood of receiving guideline-concordant care at 4 months of PCMH participation, as compared to newly enrolled individuals with a single month of participation ($p < 0.05$). This effect increased with each additional month of PCMH participation; 12 months of participation was associated with a 19.1 percentage point increase in the likelihood of receiving guideline-concordant care over a single month of participation ($p < 0.01$). **Conclusions** The PCMH model is associated with higher quality of care for patients with multiple chronic conditions and MDD over time, and these benefits increase the longer a patient is enrolled. Providers and policy makers should consider the positive effect of increased contact with PCMHs when designing and evaluating initiatives to improve care for this population.

► **Collaboration entre médecins généralistes et psychologues en libéral**

VERGÈS Y., VERNHES S., VANNESTE P., *et al.*
2021

Annales Médico-psychologiques, revue psychiatrique : Ahead of pub.

<https://doi.org/10.1016/j.amp.2021.08.014>

Psychologues et médecins généralistes (MG) sont les acteurs les plus consultés par les patients présentant des difficultés psychologiques. Ils ont chacun leur identité professionnelle, leur propre cadre de travail, leurs références et leur langage. En France, les interactions entre eux semblent rares en libéral. L'intérêt de développer la collaboration entre médecins généralistes et psychologues est étayé par les données de pratiques collaboratives en santé mentale développées à l'international, ayant montré une amélioration significative de la prise en soins et des bénéfices sur la santé des patients, ainsi que des bénéfices pour les MG et les psychologues et pour la communauté. La Haute Autorité de santé (HAS) a publié en 2018 un état des lieux et des recommandations pour améliorer la coordination entre le médecin généraliste et les différents acteurs de soins dans la prise en charge des patients adultes atteints de troubles mentaux, invitant à travailler sur de meilleures convictions, implications et cultures partagées, ainsi que sur la reconnaissance des rôles et compétences de chacun. Les professionnels interrogés dans cet entretien, trois psychologues et trois médecins généralistes, ébauchent un état des lieux de la collaboration entre psychologues et MG en France et en Belgique, rapportent leurs expériences de réalité de terrain et d'initiatives mises en place, questionnent les orientations souhaitables – notamment autour de cadres institutionnels mis en place et d'une formation professionnelle partagée – et la définition même de la notion de collaboration.

Covid

► Une revue intégrative de l'identité populaire de l'infirmière durant la pandémie de la COVID-19

BERNARD L., BÉVILLARD-CHARRIÈRE Q., TAHA S., *et al.*
2021

Recherche en soins infirmiers 145(2): 91-103.

<https://www.cairn.info/revue-recherche-en-soins-infirmiers-2021-2-page-91.htm>

Le contexte actuel lié à la Covid-19 place les infirmières au cœur de la pandémie car elles assurent un rôle essentiel auprès de la population. Toutefois, les discours médiatiques et professionnels influencent l'identité et la pratique clinique des infirmières. L'objectif de cette étude est de recenser et analyser les écrits traitant de la construction d'une identité populaire de l'infirmière et de ses rôles en temps de pandémie liée à la COVID-19. Les sources de données Eurêka, Google News, Education Resources Information Center (ERIC), Sociological Abstracts, Cumulative Index to Nursing Information and Allied Health Literature (CINAHL), MEDLINE et Social Sciences Abstracts ont été consultées. Des recherches manuelles sur les sites gouvernementaux et professionnels ont été ajoutées. Sur un total de 281 écrits répertoriés, 73 ont été retenus. L'analyse des écrits a permis de dégager les thèmes suivants : les images identitaires des infirmières durant cette pandémie et leurs rôles professionnels. Les discours autant médiatiques que politiques sont parfois paradoxaux. Ces derniers semblent influencer la pratique clinique infirmière qui se voit attribuer de nouveaux rôles. Cet article permet de sensibiliser les décideurs aux rôles multiples des infirmières et à l'image qu'a le public de ces dernières en temps de pandémie, et de porter un regard critique sur les discours populaires en lien avec l'identité infirmière et sa modulation en temps de pandémie.

► Primary Healthcare Practitioners Were in the Front Line to Deal with Covid-19 and Reorganize Their Practice to Avoid Inappropriate Use of Hospital Services

GIMENEZ L., DUPOUY J., RICORDEAU P., *et al.*
2021

La Presse Médicale Open 2: 100010-100010.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8195684/>

In front of the COVID-19 disease and the current global pandemic, all health care professionals had to adapt their practice. In most developed countries, health care systems are hospital-centered. Many publications documented the impact of the pandemic on the hospitals. In France, GPs had to locally organize their network and many initiatives were observed to maintain the follow-up of patients. Saint-Lary *et al.* showed that of 5425 GPs, 70.9% changed their activity, 66.5% increased remote consultations and 42.7% created a specific pathway for probable patients with COVID-19. Among the GPs who changed their practice, 91.7% gave more answers by phone, 27.6% by email and 30.7% increased the use of video consultations.

► Transformations in the Landscape of Primary Health Care During Covid-19: Themes From the European Region

KUMPUNEN S., WEBB E., PERMANAND G., *et al.*
2021

Health Policy : Ahead of pub.

<https://doi.org/10.1016/j.healthpol.2021.08.002>

The Covid-19 pandemic has dramatically impacted primary health care (PHC) across Europe. Since March 2020, the Covid-19 Health System Response Monitor (HSRM) has documented country-level responses using a structured template distributed to country experts. We extracted all PHC-relevant data from the HSRM and iteratively developed an analysis framework examining the models of PHC delivery employed by PHC providers in response to the pandemic, as well as the government enablers supporting these models. Despite the heterogenous PHC structures and capacities across European countries, we identified three prevalent models of PHC delivery employed: (1) multi-disciplinary primary care teams coordinating with public health to deliver the emergency response and essential services; (2) PHC providers defining and iden-

tifying vulnerable populations for medical and social outreach; and (3) PHC providers employing digital solutions for remote triage, consultation, monitoring and prescriptions to avoid unnecessary contact. These were supported by government enablers such as increasing workforce numbers, managing demand through public-facing risk communications, and pri-

oritising pandemic response efforts linked to vulnerable populations and digital solutions. We discuss the importance of PHC systems maintaining and building on these models of PHC delivery to strengthen preparedness for future outbreaks and better respond to the contemporary health challenges.

Systèmes de santé

Health Systems

► Emerging Models of Care For Individuals with Multiple Chronic Conditions

SAVITZ L. A. ET BAYLISS E. A.
2021

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

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13774>

The aim of this study is to characterize emerging and current practice models to more effectively treat and support patients with multiple chronic conditions (MCC). We conducted a rapid literature scoping augmented by key informant interviews with clinicians knowledgeable about MCC care from a broad spectrum of US delivery systems and feedback from multidisciplinary experts at two virtual meetings. Although the literature scoping did not identify a specific set of evidence-based care models, key informant discussions identified eight themes reflecting emerging approaches to population-based MCC care. For example, addressing the needs of individuals with MCC through a complexity lens by assessing and addressing social risk factors; extending the care continuum with home-based care; understanding how to address ongoing patient and caregiver supports outside of clinical encounters; and engaging available community resources. Conclusions Integrating care for MCC patient populations requires processes for determining different subpopulation needs in various settings and lived experiences. Innovation should be anchored at the nexus of payment systems, social risks, medical needs, and community-based resources. Our learnings suggest a need for an ongoing MCC care research agenda to inform new approaches to care delivery incorporating innovations in technology and home-based supports for patients and caregivers.

► Supporting Government Policies to Embed and Expand Rehabilitation in Health Systems in Europe: A Framework For Action

SKEMPES D., KIEKENS C., MALMIVAARA A., *et al.*
2021

Health Policy : Ahead of pub.

<https://doi.org/10.1016/j.healthpol.2021.06.014>

Investment in action is vital to confront the challenges associated with chronic diseases and disability facing European health systems. Although relevant policy responses are being increasingly developed, most of them fail to recognize the role of rehabilitation services in achieving public health and social goals. Comprehensive guidance is thus urgently needed to support rehabilitation policy development and expand access to rehabilitation care to meet population needs effectively. This paper describes a framework to guide policy action for rehabilitation in Europe. The framework was developed in collaboration with the European Academy of Rehabilitation Medicine based on a focused literature review and expert consultations. A review in PubMed and grey literature sources identified 458 references and resulted in 135 relevant documents published between 2006 and 2019. Thematic analysis of extracted information helped summarize the findings and develop the draft policy action framework. This was circulated to a wider group of experts and discussed in three workshops in 2018-2019. The framework was revised according to their feedback. The proposed framework contains 48 options for policy action organized in six domains and twelve subdomains that address several areas of health programming. The proposed framework provides a structure to understand the policy terrain related to

rehabilitation in Europe and the measures required for translating aspirational political pronouncements into targeted programmatic action and tangible health and social outcomes.

► **Innovative Transformation of the Health System Through a Preventive Transition**

STEVENS N., CAMBON L. ET ALLA F.
2021

Revue d'épidémiologie et de santé publique 69(4): 235-240.

Given today's evolution of the healthcare system, organizational transformations, technological developments and major challenges, innovation has taken on primordial importance. In this context and with considerable support, many experimentations have taken place. Unfortunately, few have managed to scale up. What results is a congeries of innovations without a future, possibly avoidable squandering of resources, a number of missed opportunities, and the grim prospect of inventor burnout. As regards prevention, innovation is at the heart of an anticipated «preventive transition» of the health system that has yet to achieve operational status. In this article we attempt to redesign the contours of innovation in health, considering it first and foremost in regard to its social utility. We will go on to explore the limitations of innovative practices that delay the arrival of advances in health. Four types of obstacles appear: faulty evaluation; insufficient dialogue between researchers, stakeholders and decision-makers; lack of visibility and, finally, conceptions and perceptions of innovation characterized by tunnel vision. In the concluding section of this paper, we will present several tracks through which the innovation process could be impelled to drive health system transformation. They consist in: (i) incorporating an evaluative and comprehensive research into innovation processes, (ii) elaborating «bottom-up» approaches giving special consideration to innovations instigated by stakeholders and brought to fruition under real-life conditions, (iii) breaking from standardization by thinking from the outset of the adaptability of innovations and, finally, (iv) tying in the experimental approach with a decision-making process.

► **En Suède, les agences de sécurité sanitaire disposent de larges pouvoirs**

TEGNELL A.
2021

Revue française des affaires sociales(2): 125-132.

<https://www.cairn.info/revue-francaise-des-affaires-sociales-2021-2-page-125.htm>

Quelle est l'organisation adoptée par la Suède pour la gestion de la crise sanitaire? En tant qu'agence de santé publique, Folkhälsomyndigheten (FHM) a la responsabilité de coordonner l'ensemble des décisions et des actions lorsqu'il s'agit d'identifier une maladie infectieuse et d'y répondre. C'est donc notre rôle de coordonner tout cela. Il y a, en Suède, une loi sur les maladies infectieuses (Communicable Diseases Act) qui donne aux agences un pouvoir de réglementation dont elles font usage. Elles ont une large capacité d'action. Au niveau national, les agences suédoises ont donc un mandat plus étendu que les mêmes agences en France, par exemple.

► **Public Satisfaction with Health Care System in 30 Countries: The Effects of Individual Characteristics and Social Contexts**

YUAN Y.
2021

Health Policy : Ahead of pub.

<https://doi.org/10.1016/j.healthpol.2021.08.005>

In this article, the associations among individual socio-economic characteristics, the institutional set-up of health care systems, and satisfaction with the health care system are investigated. Data from the 2011 International Social Survey Program (30 countries, 34,212 respondents) is used. Multilevel analyses across countries have shown how the state financing context affects satisfaction at the individual level. Consistent with previous research, at individual level, personal experiences with medical providers, age, gender as well as income are significant predictors of satisfaction with the health care system. At the country level, real input indicators such as density of physicians and density of hospital beds are negative predictors of satisfaction with the health care system whereas the percentage of total health expenditures comprised by public sources is a positive predictor of satisfaction with the health care system. However, findings from the cross-level interactions indicate that the negative effect of lower income is more prominent in

predominately publicly-funded health care systems. Specifically, in primarily publicly-funded health care systems, the model-predicted probability of satisfaction with the health care system is higher, but the gap in the probability of satisfaction with the health care system between individuals with lower income and

those with higher income is greater than that in mostly privately-financed health care systems. The findings in this study suggest that the future direction of health care system reform should be focused on balancing the distribution of resources between private and public sectors.

Covid

► **Le système de santé français à l'épreuve de la pandémie**

BONNICI B.
2021

Gestions hospitalières(607): 339-343.

À l'orée d'une prochaine sortie de crise à l'automne prochaine, cet article rembobine le film d'événements souvent tragiques vécus depuis le début de l'année 2020 et fait le bilan de la robustesse du système de santé français à l'épreuve de la pandémie de la Covid-19.

► **Les patients : La pandémie révélatrice de leur place dans le système de santé. Dossier**

BUDET J. M., KOUEVI A., SIMARD I., *et al.*
2021

Gestions hospitalières(606): 284-317.

Le discours permanent des autorités sanitaires, des établissements et des professionnels est de construire un système de santé centré sur le patient. Le projet gouvernemental « Ma santé 2022 » vise ainsi à placer le patient au cœur du système, à faire de la qualité de sa prise en charge la boussole de la réforme et à créer un collectif de soins au service des patients. Cela ressemble beaucoup à la définition de ce que devrait être le service public et aux devoirs des codes de déontologie. Mais c'est toujours dans les épreuves que l'on mesure la solidité d'un discours, des engagements et des principes. La crise liée au Covid-19 a été et est à cet égard révélatrice de la véritable place octroyée au patient, tant par les autorités sanitaires que par les professionnels et établissements de santé. La situation des résidents des Ehpad a illustré à l'extrême l'incompréhension et les souffrances tant les valeurs affichées et partagées ont été remises au nom de la sécurité sanitaire et du rejet de toute prise de risque. Pendant que les soignants se dévouaient pour soigner au risque

même de leur santé, pendant que d'autres restaient confinés volontaires avec les résidents, des questions éthiques surgissaient au décours de la saturation hospitalière à propos du tri des malades, de l'accompagnement de la fin de vie, de l'information et du consentement, du droit de visite, de la déprogrammation et de la perte de chance. Ce dossier aborde l'ensemble de ces problématiques.

► **Post-Covid-19 Health Care System: A Call For Community-Based, Person-Centered, and Primary Care-Driven Care**

MOON J. R. ET FALICK ASCHER A.
2021

American Journal of Public Health 111(8): 1451-1455.

<https://doi.org/10.2105/AJPH.2021.306160>

It has been seven months since the beginning of New York State's emergency response to the COVID-19 pandemic. As of this writing, there have been 7.7 million Covid-19 cases and 214 000 deaths in the United States. SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2) and Covid-19 represent an unprecedented threat to the lives and livelihoods of our community—globally, nationally, and locally. It has become clear that COVID-19 is not the great “equalizer” but quite the opposite, magnifying and bringing to the fore the detrimental, unignorable impact of long-standing systemic inequities. To focus beyond the disparities in Covid-19 fatalities and the disproportionate burden on hospitals and critical care, we must think about equitable strategies to address the longer-term health and socioeconomic impact.

► **Assessing the Indirect Effects of COVID-19 on Healthcare Delivery, Utilization and Health Outcomes: A Scoping Review**

ROY C. M., BOLLMAN E. B., CARSON L. M., *et al.*
2021

European Journal of Public Health 31(3): 634-640.
<https://doi.org/10.1093/eurpub/ckab047>

The COVID-19 pandemic and global efforts to contain its spread, such as stay-at-home orders and transportation shutdowns, have created new barriers to accessing healthcare, resulting in changes in service delivery and utilization globally. The purpose of this study is to provide an overview of the literature published thus far on the indirect health effects of COVID-19 and to explore the data sources and methodologies being used to assess indirect health effects. A scoping review of peer-reviewed literature using three search engines was performed. One hundred and seventy studies were included in the final analysis. Nearly half (46.5%) of included studies focused on cardiovascular health outcomes. The main methodologies used were observational analytic and surveys. Data were drawn from individual health facilities, multicentre networks, regional registries, and national health information systems. Most studies were conducted in high-income countries with only 35.4% of studies representing low- and middle-income countries (LMICs). Healthcare utilization for non-Covid-19 conditions has decreased almost universally, across both high- and lower-income countries. The pandemic's impact on

non-Covid-19 health outcomes, particularly for chronic diseases, may take years to fully manifest and should be a topic of ongoing study. Future research should be tied to system improvement and the promotion of health equity, with researchers identifying potentially actionable findings for national, regional and local health leadership. Public health professionals must also seek to address the disparity in published data from LMICs as compared with high-income countries.

► **Post-Pandemic Transformation of Healthcare Delivery in Provinces and Territories**

SUTHERLAND J.
2021

Healthcare Policy 17(1): 1-11.

<https://www.longwoods.com/content/26583/healthcare-policy/post-pandemic-transformation-of-healthcare-delivery-in-provinces-and-territories>

Many new policies, procedures and physical spaces were used to deliver healthcare during the COVID-19 pandemic in order to provide critical care and lessen the risks of transmission within healthcare organizations and among providers, patients, their families and the community. As reopening unfolds, some of the significant challenges facing the federal government, provinces and territories are these: What new practices and behaviours should be retained in the post-pandemic era? How will the changes be paid for?

Travail et santé

Occupational Health

► **La place de la médecine du travail ne peut se mesurer exclusivement au seul nombre de médecins du travail**

FANTONI-QUINTON S. ET VERKINDT P. Y.
2021

Droit Social(6):539.

Ce texte est le résultat d'un séminaire « Penser le droit social » organisé par le département de droit social de l'Institut de recherches juridiques de la Sorbonne (Paris 1). Ce séminaire part du constat que dans un contexte caractérisé par une frénésie législative, les principes

qui sont au fondement du droit social se dissolvent jusqu'à parfois disparaître complètement à la vue de ceux qui l'analysent ou l'appliquent.

► **The Asymmetric Experience of Gains and Losses in Job Security on Health**

LEPINTEUR A.
2021

Health Economics 30(9): 2217-2229.

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4369>

Is workers' health more sensitive to losses than gains in job security? I address this question using the 1999 rise

in the French Delalande tax as a quasi-natural experiment. The tax design allows to separately identify the causal impact of exogenous gains and losses in job security on workers' health. Difference-in-differences estimation results show that a greater job insecurity reduces significantly self-reported health. At the same time, more job security does not translate into a higher level of self-reported health.

Covid

► **Clinical and Laboratory Characteristics of Symptomatic Healthcare Workers with Suspected COVID-19: A Prospective Cohort Study**

BAL A., BRENGEL-PESCE K., GAYMARD A., *et al.*
2021

Scientific Reports 11(1): 14977.

<https://doi.org/10.1038/s41598-021-93828-y>

A comprehensive clinical and microbiological assessments of COVID-19 in front-line healthcare workers (HCWs) is needed. Between April 10th and May 28th, 2020, 319 HCWs with acute illness were reviewed. In addition to SARS-CoV-2 RT-PCR screening, a multiplex molecular panel was used for testing other respiratory pathogens. For SARS-CoV-2 positive HCWs, the normalized viral load, viral culture, and virus neutralization assays were performed weekly. For SARS-CoV-2 negative HCWs, SARS-CoV-2 serological testing was performed one month after inclusion. Among the 319 HCWs included, 67 (21.0%) were tested positive for SARS-CoV-2; 65/67 (97.0%) developed mild form of COVID-19. Other respiratory pathogens were found in 6/66 (9.1%) SARS-CoV-2 positive and 47/241 (19.5%) SARS-CoV-2 negative HCWs ($p = 0.07$). The proportion of HCWs with a viral load $> 5.0 \log_{10}$ cp/mL (Ct value < 25) was less than 15% at 8 days after symptom onset; 12% of HCWs were positive after 40 days (Ct > 37). More than 90% of cultivable virus had a viral load $> 4.5 \log_{10}$ cp/mL (Ct < 26) and were collected within 10 days after symptom onset. Among negative HCWs, 6/190 (3.2%) seroconverted. Our data suggest that the determination of viral load can be used for appreciating the infectiousness of infected HCWs. These data could be helpful for facilitating their return to work.

► **Télétravail contraint en pandémie, nouveau risque psychosocial : réflexions sur les enjeux santé et l'accompagnement nécessaire**

CHAMOIX A.
2021

Bulletin de l'Académie Nationale de Médecine : Ahead of pub.

<https://doi.org/10.1016/j.banm.2021.05.015>

Avec la pandémie COVID-19 les mesures barrières ont aussi concerné le monde du travail. Particulièrement le télétravail a été encouragé sur une longue période en France puis généralisé en avril 2021 favorisant un isolement social. Le climat anxiogène lié à la pandémie et le caractère précipité de cette décision représentent un nouveau facteur de risque psychosocial. Les manifestations psychologiques liées au stress : troubles anxieux dépressifs et autres justifient sans attendre un plan d'action global avec mesures d'accompagnement systématiques par le management de proximité, dépistage systématique d'éventuelle désadaptation par les services de santé au travail et prise en charge des personnes en difficulté. Pour cela et dans ces circonstances, les auto-questionnaires, questionnaires dirigés et entretiens en vidéo apparaissent comme les moyens les plus adaptés. Le télétravail choisi et à temps partiel permettant de concilier vie familiale et vie professionnelle restera une solution à certains moments de la vie mais le télétravail à temps complet ne peut constituer une solution univoque et durable.

► **Were Immigrants on the Frontline During the Lockdown? Evidence From France**

GOSSELIN A., MELCHIOR M., DESPRAT D., *et al.*
2021

European Journal of Public Health : ckab094

<https://doi.org/10.1093/eurpub/ckab094>

In France, immigrants' excess of mortality was higher than natives' during the Spring 2020 lockdown. Were immigrants in frontline jobs and more exposed to Covid-19? Based on a nationally representative survey, we model the probability to work in a frontline job according to migratory status, taking sociodemographic and occupational characteristics into account. Compared to natives (Metropolitan France), being an African immigrant was associated to higher probability to work in a frontline job [adjusted odds ratio (aOR) = 1.82 (1.23–2.71)], as well as being born in French Overseas Departments [aOR = 1.64 (1.23–2.18)], reflecting racial division of work and higher Sars-Cov-2 exposure of immigrant and minority populations.

► **Comment la pandémie de Covid-19 a-t-elle bouleversé le rapport au travail ?**

LEROYER A., LESCURIÉUX M. ET VIERA GIRADO V.
2021

Connaissance De L'emploi(172): 4.

<https://halshs.archives-ouvertes.fr/halshs-03273569/>

<https://ceet.cnam.fr/publications/connaissance-de-l-emploi/comment-la-pandemie-de-covid-19-a-t-elle-bouleverse-le-rapport-au-travail--1271449.kjsp>

Depuis le mois de mars 2020, la pandémie de la Covid-19 a profondément modifié l'organisation du travail des personnes en emploi en impactant de manière variée les différentes catégories de travailleur.e.s. Au gré de la crise sanitaire, les situations de travail des salarié.e.s ont plus ou moins évolué sans qu'une ligne directrice prédomine. Mais alors que de nouvelles formes d'organisation de l'activité se sont développées, le rapport au travail des salarié.e.s a-t-il été bouleversé ? Si oui, comment et pour qui ? À partir d'une analyse statistique des données de l'observatoire Evrest et d'une recherche qualitative menée sur le vécu du premier confinement pour des familles, ce numéro de Connaissance de l'emploi cherche à comprendre les facteurs de variabilité du rapport au travail en lien avec la crise sanitaire traversée. Cette étude montre des effets inégaux et contrastés, en particulier selon le genre et de la classe sociale des salarié.e.s.

Vieillessement

Ageing

► **How Quality Improvement Collaboratives Work to Improve Healthcare in Care Homes: A Realist Evaluation**

DEVI R., CHADBORN N. H., MEYER J., *et al.*
2021

Age and Ageing 50(4): 1371-1381.

<https://doi.org/10.1093/ageing/afab007>

Quality improvement collaboratives (QICs) bring together multidisciplinary teams in a structured process to improve care quality. How QICs can be used to support healthcare improvement in care homes is not fully understood. A realist evaluation to develop and test a programme theory of how QICs work to improve healthcare in care homes. A multiple case

study design considered implementation across 4 sites and 29 care homes. Observations, interviews and focus groups captured contexts and mechanisms operating within QICs. Data analysis classified emerging themes using context-mechanism-outcome configurations to explain how NHS and care home staff work together to design and implement improvement. QICs will be able to implement and iterate improvements in care homes where they have a broad and easily understandable remit; recruit staff with established partnership working between the NHS and care homes; use strategies to build relationships and minimise hierarchy; protect and pay for staff time; enable staff to implement improvements aligned with existing work; help members develop plans in manageable chunks through QI

coaching; encourage QIC members to recruit multidisciplinary support through existing networks; facilitate meetings in care homes and use shared learning events to build multidisciplinary interventions step-wise. Teams did not use measurement for change, citing difficulties integrating this into pre-existing and QI-related workload. These findings outline what needs to be in place for health and social care staff to work together to effect change. Further research needs to consider ways to work alongside staff to incorporate measurement for change into QI.

► **Does Public Long-Term Care Expenditure Improve Care-Related Quality of Life of Service Users in England?**

LONGO F., CLAXTON K., LOMAS J., *et al.*
2021

Health Economics : Ahead of pub.

<https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4396>

Public long-term care (LTC) systems provide services to support people experiencing difficulties with their activities of daily living. This study investigates the marginal effect of changes in public LTC expenditure on care-related quality of life (CRQoL) of existing service users in England. The public LTC program for people aged 18 or older in England is called Adult Social Care (ASC) and it is provided and managed by local authorities. We collect data on the outcomes and characteristics of public ASC users, on public ASC expenditure, and on the characteristics of local authorities across England in 2017/18. We employ an instrumental variable approach using conditionally exogenous elements of the public funding system to estimate the effect of public ASC expenditure on user CRQoL. Our findings show that by increasing public ASC expenditure by £1000 per user, on average, local authorities increase user CRQoL by 0.0030. These results suggest that public ASC is effective in increasing users' quality of life but only to a relatively small extent. When combined with the other potential effects of LTC expenditure (e.g., on informal carers, mortality), this study can inform policy makers in the United Kingdom and internationally about whether social care provides good value for money.

► **Healthy Life Expectancy By Frailty State in Europe From 2004 to 2015: Findings From SHARE**

NIELSEN C. R., AHRENFELDT L. J., JEUNE B., *et al.*
2021

European Journal of Public Health 31(3): 554-560.

<https://doi.org/10.1093/eurpub/ckab012>

As populations age, the possible consequences of increased frailty are a major concern for the health sector. Here, we investigate how life expectancy with and without frailty has changed during a 10–11-year-period across Europe. The Sullivan method was used to investigate changes in life expectancy with and without frailty in 10 European countries. Frailty status (non-frail, pre-frail and frail) was determined by use of the Survey of Health, Ageing and Retirement in Europe Frailty Instrument (SHARE-FI). Data on frailty prevalence was obtained from 21 698 individuals in wave 1 (2004–05) and 38 859 individuals in wave 6 (2015) of the SHARE. Information on mortality was obtained from the Eurostat Database. In 2015, women aged 70 spent 25.0% (95% CI: 24.0–26.1) of their remaining life expectancy in a frail state, and the number for men was 11.5% (95% CI: 10.7–12.3). Southern Europeans spent 24.2% (95% CI: 22.9–25.4) of their remaining life expectancy in a frail state and the numbers for Central Europeans and Northern Europeans were 17.0% (95% CI: 16.0–17.9) and 12.2% (95% CI: 10.9–13.5), respectively. From 2004–05 to 2015, life expectancy increased by 1.1 years (from 15.3 to 16.4 years) for 70-year-old Europeans. Similarly, non-frail life expectancy increased by 1.1 years (95% CI: 0.8–1.4), whereas no significant changes in life expectancy in frail states were observed. This study suggests that Europeans today spend more years in a non-frail state than Europeans did 10–11 years ago. Our findings reflect a considerable inequality by gender and region.

► **Social Network Characteristics As Correlates and Moderators of Older Adults' Quality of Life—The SHARE Study**

SCHMIDT T., CHRISTIANSEN L. B., SCHIPPERIJN J., *et al.*
2021

European Journal of Public Health 31(3): 541-547.

<https://doi.org/10.1093/eurpub/ckab001>

The quality of life (QoL) of older adults is a key aspect of healthy ageing, and older adults' socioeconomic status (SES), the neighbourhood they live in and their social networks (SN) are known to impact QoL.

However, little is known about the interaction between these concepts. The aim was to examine how SN, SES and neighbourhood type are associated with QoL in older adults.: Wave 4 (year 2011) and wave 6 (year 2015) data from the longitudinal Survey of Health, Ageing and Retirement in Europe were used for the analysis. Multilevel regression models estimated the associations including 34 792 participants from wave 4 and 67 334 participants from wave 6 from 16 countries (mean age = 66.45 years). The outcome variable was QoL, independent variables were SES (education and making end meet) and neighbourhood type (housing type and housing area), and SN variables (satisfaction and size) were the moderators.: SES and SN variables were positively associated with QoL. Living in a house or duplex was positively associated with QoL compared with living in a farmhouse. SN moderated the association between education and QoL. The effect of area type on QoL was moderated by SN size. SN satisfaction was an independent correlate of QoL.: Older adults' satisfaction with their SN may be more important than having a large SN. Low SES older adults may be more prone to having weak SN. Maintaining and creating supportive SN may attenuate the negative effects of low SES or less favourable neighbourhood characteristics.

► **An International Comparison of Long-Term Care Trajectories and Spending Following Hip Fracture**

WODCHIS W. P., OR Z., BLANKART C. R., *et al.*
2021

Health Services Research : Ahead of pub.

<https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13864>

The objectives of this study are to compare the relative use of different postacute care settings in different countries and to compare three important outcomes as follows: total expenditure, total days of care in different care settings, and overall longevity over a 1-year period following a hip fracture. Data Sources We used administrative data from hospitals, institutional and home-based long-term care (LTC), physician visits, and medications compiled by the International Collaborative on Costs, Outcomes, and Needs in Care (ICCONIC) from five countries as follows: Canada, France, Germany, the Netherlands, and Sweden. Data were extracted from existing administrative data systems in each participating country. This is a retrospective cohort study of all individuals admitted to acute care for hip fracture. Descriptive comparisons were used to examine aggregate institutional and home-based postacute care. Care trajectories were created to track sequential care settings after acute-care discharge through institutional and community-based care in three countries where detailed information allowed. Comparisons in patient characteristics, utilization, and costs were made across these trajectories and countries. Principal Findings Across five countries with complete LTC data, we found notable variations with Germany having the highest days of home-based services with relatively low costs, while Sweden incurred the highest overall expenditures. Comparisons of trajectories found that France had the highest use of inpatient rehabilitation. Germany was most likely to discharge hip fracture patients to home. Over 365 days, France averaged the highest number of days in institution with 104, Canada followed at 94, and Germany had just 87 days of institutional care on average. In this comparison of LTC services following a hip fracture, we found international differences in total use of institutional and noninstitutional care, longevity, and total expenditures. There exist opportunities to organize postacute care differently to maximize independence and mitigate costs.

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