# Clearinghouse on Health Indexes

National Center for Health Statistics
Number 1, 1987

## Bibliography on Health Indexes

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## ACKNOWLEDGMENTS

Overall responsibilities for planning and coordinating the content of this issue rested with the Clearinghouse on Health Indexes, which is located in the Health Status Measurement Branch, Division of Epidemiology and Health Promotion, Office of Analysis and Epidemiology. The bibiliography is compiled and edited by Pennifer Erickson with the assistance of Luz Chapman. Final publication was formatted by Annette Gaidurgis of the Publications Branch, Division of Data Services, Office of Data Processing and Services.

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This issue contains annotated citations of literature on composite measures of health status and quality of life, both published and unpublished, that became available in January, February, or March 1987. Materials searched in the preparation of this issue are given in the section entitled Sources of Information which follows the annotations. Bibliographic citations are given in the standard form: author, title, and source of the article, designated by Au:, Ti:, and So:, respectively. As many as five authors are listed; the sixth and additional authors are identified by et al. Abbreviations are avoided whenever possible.

Following the abstract, the number of references used in the preparation of the document and source of the annotation are given. There are four sources: (1) the author abstract designated by AA; (2) the author summary by AS; (3) the author abstract or summary modified by Clearinghouse personnel AA-M or AS-M; and, (4) the Clearinghouse abstract by CH-P where the initial following the '-' indicates the individual responsible for the abstract.

Copies of items cited in the Clearinghouse bibliographies should be requested directly from the authors. The address for reprints is given after the abstract. When the request is to be sent to an author other than the first listed, the appropriate name is given along with the address.

**REFERENCE NUMBER 1**

Au: Applegate William B.; Miller, Stephen T.; Elam, Janet T.; Freeman, Jerre M.; Wood, Thomas O. et al.
Ti: **Impact of Cataract Surgery with Lens Implantation on Vision Physical Function in Elderly Patients**
So: *Journal of the American Medical Association* 257(8):1064–1066, 1987

We conducted a prospective study of 293 elderly patients undergoing cataract surgery with intraocular lens implantation to determine the impact of the surgery on vision and on subjective and objective measures of patient function. Visual acuity in the surgical eye improved from a mean of 20/100 before surgery to 20/40 four months after surgery; improvement was maintained at one year. Positive changes occurred in some subjective measures of patient function, such as reported activities of daily living and patient report of vision-dependent activities, but these changes were modest. The most marked changes in patient function occurred in objective measures of function. Mental status had improved not quite significantly at four months but significantly at one year. Timed manual performance improved dramatically and significantly at four months and one year. Cataract surgery was associated with improved vision and improved objective function in most patients by four months after surgery, and these improvements were maintained at one year. (8 references) AA

Address for reprint requests: 66 North Pauline, Suite 232, Memphis, Tennessee 38163

**REFERENCE NUMBER 2**

Au: Applegate, William B.
Ti: **Use of Assessment Instruments in Clinical Settings**
So: *Journal of the American Geriatrics Society* 35:45–50, 1987

In recent years, increased emphasis has been placed in the field of geriatric medicine on the need for multidimensional assessment of elderly patients. There is an increasing tendency to use standardized structured assessment instruments or questionnaires in this process. Frequently, the exact question or set of questions to be answered by the instrument has not been carefully analyzed. Although comprehensive structured multidimensional instruments allow the collection of large amounts of data in multiple domains (physical, social, psychologic, economic), these instruments may require excess data collection and may not be reliable in clinical settings. Clinicians considering using a variety of assessment instruments should carefully consider their goals for data collection and carefully review the validity, reliability, and population sampled for any assessment instruments under consideration. Also, the clinical setting in which the instrument is to be used can have a negative impact on either instrument validity or reliability. (21 references) AA

Address for reprint requests: 66 North Pauline, Suite 232, Memphis, Tennessee 38163

REFERENCE NUMBER 3

Au: Arling, Greg
Ti: **Strain, Social Support, and Distress in Old Age**
So: *Journal of Gerontology* 42(2):107–113, 1987

This analysis examined the relationship between lifestrain (e.g., physical health problems, economic deprivation, and ADL impairment) and psychosomatic and emotional distress in old age, while taking into account the effects of age, race, sex, education, social support, and other measures of social resources. The data were drawn from a statewide household survey (n = 2,146) of non-institutionalized older people. Using multiple regression analysis with tests for statistical interaction, the findings revealed that women, whites, those living alone, and those with less education had greater sources of strain. Individuals with greater sources of strain were also more likely to receive social support, although they tended to have smaller social networks and less social contact. Health status and ADL were the strongest predictors of distress. Social support had a moderating influence on the relationship between ADL impairment and psychosomatic symptoms of distress. Other measures for social resources, such as living arrangement and support network size, had neither main nor interactive effects on distress. The findings were discussed in light of their implications for future research. (23 references) AA

Address for reprint requests: Department of Industrial Engineering and Center for Health Systems Research and Analysis, Room 300 Infirmary, 1300 University Avenue, Madison, Wisconsin 53706

REFERENCE NUMBER 4

Au: Avison, William R.; Speechley, Kathy Nixon
Ti: **The Discharged Psychiatric Patient: A Review of Social, Social-Psychological, and Psychiatric Correlates of Outcome**
So: *American Journal of Psychiatry* 144(1):10–18, 1987

The authors review research over the past decade on the social, social-psychological, and psychiatric correlates of community adaptation among discharged psychiatric patients. A review of 33 studies suggests that little theoretical or methodological progress has been made in identifying the factors that are conducive to the adjustment of discharged patients on their return to the community. To stimulate subsequent efforts in this area, the authors suggest applying new approaches, such as the stress process perspective that has been used to study mental health in the general population. (58 references) AA

Address for reprint requests: Health Care Research Unit, Kresge Bldg., University of Western Ontario, London, Ontario, Canada N6A 5C1.

REFERENCE NUMBER 5

Au: Bech, P.; Hjortso, S.; Lund, K.; Vilmar T.; Kastrup M.
Ti: **An Integration of the DSM-III and ICD-8 by Global Severity Assessments for Measuring Multidimensional Outcomes in General Hospital Psychiatry.**
So: *Acta Psychiatrica Scandinavica* 75:297–306, 1987

A multiaxial classification system has been developed in which three ICD-8 derived axes of psychiatric syndromes, personality disorders and somatic syndromes, and two DSM-II axes of psychosocial stressors and social functioning have been included. Global assessment scales were annexed to the three ICD-8 axes.

This DSM-III/ICD-8 system was used for registration of 880 consecutively admitted psychiatric patients in a general hospital setting. The results showed that six psychiatric syndromes (substance use disorders, schizophrenia, manic-depressive psychosis, reactive psychosis, neurosis, and adjustment reactions) were responsible for 80 of the diagnostic variance. Of these syndromes, manic-depressive psychosis had the highest improvement rate both concerning symptoms and social functioning. Manic depressive psychosis had also the lowest coefficient of variation in the stay in hospital indicating a high degree of homogeneity in accordance to the diagnosis-related group system. However, patients within the categories of reactive psychosis and neurosis who received antidepressants also had a low coefficient of variation, although the neurotics were significantly more depressed than the manic-depressives at discharge from hospital. (25 references) AA

Address for reprint requests: Frederiksborg General Hospital Department of Psychiatry, 48 Dyrehavevej, DK-3400 Hillerod, Denmark

## REFERENCE NUMBER 6

Au: Binns, T.B.
Ti: **Value for Money in Health Care**
So: *Lancet I*(8523):54–57, 1987

This article discusses the need for interaction between health care delivery persons and health policy makers, especially economists; it is suggested that this need is increasing due to the rising cost of providing quality health care. As one ingredient in addressing this need, the author calls for an expanded use of outcome measures, including quality-adjusted life years. (11 references) CH-P

Address for reprint requests: 15 The Causeway, Horsham, Sussex, United Kingdom RH12 1HE

## REFERENCE NUMBER 7

Au: Chubon, Robert A.
Ti: **Development of a Quality-of-Life Rating Scale for use in Health-Care Evaluation**
So: *Evaluation and the Health Professions* 10(2):186–200, 1987

Many concepts derived from quality-of-life measurement research have been deemed appropriate for use in health-care research. However, available life-quality measurement instruments developed for use with chronically ill and disabled populations have limited research quality because of their relatively narrow foci. Development of a more widely applicable measure was undertaken, and the resultant instrument is described. Potential uses are also discussed. (23 references) AA

Address for reprint requests: Department of Educational Psychology, University of South Carolina, Columbia, South Carolina 29208

## REFERENCE NUMBER 8

Au: Clark, W.A.V.; Freeman, H.E.; Kane, R.; Lewis, C.E.
Ti: **The Influence of Domestic Position on Health Status**
So: *Social Science and Medicine* 24(6):501–506, 1987

Data from the Robert Wood Johnson Foundation 1982 survey of access to health care are used to examine the influence of household composition and members' domestic position, e.g., age, sex, marital status, and presence of children, on health status and use of health services. A hierarchical analysis was undertaken to sort groups of individuals and households having different domestic structures. The results of the analyses of use and access for these groups show that, after controlling for age, domestic position and household arrangements are significant explanatory variables. Ways to refine the approach are discussed. (13 references) AA

Address for reprint requests: Department of Geography, University of California, Los Angeles, California 90024

**REFERENCE NUMBER 9**

Au: Costa, Paul T. Jr.; Zonderman, Alan B.; McCrae, Robert R.; Cornoni-Huntley, Joan, Locke, Ben Z. et al.
Ti: **Longitudinal Analyses of Psychological Well-Being in a National Sample: Stability of Mean Levels**
So: *Journal of Gerontology* 42(1):50–55, 1987

Maturational changes, cohort differences, and time of measurement effects on psychological well-being were examined in data from the National Health and Nutrition Examination Survey (NHANES) I Epidemiologic Followup Study. A 9-year longitudinal study of 4,942 men and women initially ages 25 to 74 was supplemented by cross- and time-sequential analyses using and independent sample of 4,986 participants who were first administered the well-being measures at the time of the follow-up. Older participants in the study tended to be lower in both Positive and Negative Affect, but longitudinal changes in these two subscales were not found, and Total Well-Being showed no significant age, birth cohort, or time effects in any of the analyses. Given the size and representativeness of the sample, this is strong evidence of the stability of mean levels of psychological well-being in adulthood, and points to the importance of enduring personality dispositions and processes of adaptation in determining levels of well-being. (26 references) AA

Address for reprint requests: Laboratory of Personality and Cognition, Department of Health and Human Services, 4940 Eastern Avenue, Baltimore, Maryland 21224

**REFERENCE NUMBER 10**

Au: Dane, J.K.; Sleet, David A.; Lam, David J.; Roppel, Charles E.
Ti: **Determinants of Wellness in Children: An Exploratory Study**
So: *Health Values* 11(1):13–19, 1987

The factors believed to influence children's health and wellness were derived from the professional judgment of an advisory panel composed of experts in preventive medicine, health education, and child development. The panel was polled by mail in a delphi-like series of structured inquiries to gather information about the physical, social, and emotional characteristics of healthy children ages 6 to 11. Knowledge, attitudes, and behaviors appropriate to the promotion or support of those characteristics were delineated. The study resulted in identification of 35 attributes considered important in the development of healthy children. (16 references) AA

Address for reprint requests: Department of Health Science and Division of Health Promotion, San Diego State University, San Diego, California 92182

**REFERENCE NUMBER 11**

Au: Daniels, Denise; Miller, John J.; Billings, Andrew G.; Moos, Rudolf H.
Ti: **Psychosocial Functioning of Siblings of Children with Rheumatic Disease.**
So: *Journal of Pediatrics* 109(2):379–383, 1986

The potential impact of an ill child on other siblings in the family was examined by comparing 72 siblings of children with rheumatic disease with 60 siblings of healthy children from demographically matched families. Psychosomatic, behavioral, emotional, and social problems, as reported by both the parents and the siblings, were investigated. Although siblings of patients with rheumatic disease generally were functioning as well as siblings of healthy children, they reported having more allergies and asthma. A set of vulnerability and protective factors was tested as predictors of sibling functioning. Cohesive and expressive family environments in which mothers and patients with rheumatic disease were functioning adequately promoted better adaptation among the siblings. (18 references) AA

Address for reprint requests: Social Ecology Laboratory, Department of Psychiatry and Behavioral Sciences, TD-114, Stanford University Medical Center, Stanford, California 94305

**REFERENCE NUMBER 12**
Au: Deimling, Gary T.; Bass, David M.
Ti: **Symptoms of Mental Impairment Among Elderly Adults and Their Effects on Family Caregivers**
So: *Journal of Gerontology* 41(6):778–784, 1986

Research that has examined the relationship between caregiving stress and elders' symptoms of mental impairment has focused primarily on cognitive incapacity. This research expands the symptoms of mental impairment to include caregivers' reports of problems in elders' social functioning and the presence of disruptive behaviors, in addition to the traditional measure of cognitive incapacity. Results from a study of 614 families living with and caring for an impaired elder show cognitive incapacity to have a less important direct effect on caregiving stress than disruptive behavior and impaired social functioning. Cognitive incapacity does have an important indirect effect through its influence on disruptive behavior and social functioning. (24 references) AA

Address for reprint requests: The Margaret Blenkner Research Center, The Benjamin Rose Institute, 500 Hamma Building, 1422 Euclid Avenue, Cleveland, Ohio 44115-1989

**REFERENCE NUMBER 13**
Au: Del Greco, Linda
Ti: **Questionnaire Development: 1. Formulation**
So: *Canadian Medical Association Journal* 136(6):583–586, 1987

This article is the first of a five-part series designed to acquaint the reader with the process of questionnaire construction. This information is intended to help researchers (1) review studies that have used questionnaires, (2) select a questionnaire for one's use or (3) formulate a questionnaire. This series is not meant to be definitive but, rather, is presented as a convenient introduction to the development of questionnaires. For a more in-depth view of the topic the reader is should consult the list references provided. (26 references) AS

Address for reprint request: New York Hospital 21 Bloomingdale Road, White Plains, New York 10605

**REFERENCE NUMBER 14**
Au: Garner, Thesia I.; Dardis, Rachel
Ti: **Cost-effectiveness Analysis of End-Stage Renal Disease Treatments**
So: *Medical Care* 25(1):25–34, 1987

The cost-effectiveness of various end-stage renal disease (ESRD) treatments was compared using two different cost measures. The first measure, gross social costs, excluded output gains due to treatment, whereas the second measure, net social cost, included output gains from both market and non-market activities. The costeffectiveness criterion was the cost-per-life year gained or the implicit value of a year of life. The lower the cost-per-life year gained, the more cost-effective the treatment was. Four ESRD treatments were evaluated over 20 years. Home dialysis and transplantation were more costeffective than in-center dialysis, regardless of whether gross of net social costs were used. However, lower values were obtained in the case of net social costs reflecting a provision for output gains due to treatment. The use of net social costs also resulted in greater variation in cost-per-life year gained by age. Changes in survival probabilities affected the results for transplant patients and dialysis patients differently. (23 references) AA

Address for reprint requests: Rachel Dardis, Department of Textiles and Consumer Economics, University of Maryland, College Park, Maryland 20742

**REFERENCE NUMBER 15**

Au: Gibson, D.M.
Ti: **Interaction and Well-Being in Old Age: Is It Quantity or Quality that Counts?**
So: *International Journal of Aging and Human Development* 24(1):29–40, 1986–87

This article explores the relationship between two dimensions of social interaction and well-being, controlling for the key antecedent variables of health and income. The two dimensions of interaction relate to the quantity and adequacy of social contact. Using more comprehensive indicators of social interaction than are generally available, the results indicate that it is the respondent's assessment of the adequacy of his or her social contact, rather than the amount of social contact per se, that is a critical determinant of well being in old age. (35 references) AA

Address for reprint requests: School of Humanities Griffith University Nathan, Brisbane, Queensland 4111 Australia

**REFERENCE NUMBER 16**

Au: Glatzer, Wolfgang
Ti: **Subjective Well-Being: Components of Well-Being**
So: *Social Indicators* 19(1):25–37, 1987

In this report, well-being is assessed in terms of happiness and satisfaction. On a scale ranging from 0 to 10, with low scores representing lower levels of satisfaction, the average life satisfaction score for Germans was 7.8 in 1980 and 7.7 in 1984. In 1980, 26 percent indicated that they were very happy; in 1984, 20 percent were very happy. The percent of persons responding as quite unhappy increased over the 4 year interval. The happiness and satisfaction data are further examined according to various socio-demographic population subgroups. (number of references unknown) CH-P

Address for reprint requests: Address unknown.

**REFERENCE NUMBER 17**

Au: Glatzer, Wolfgang; Mohr, Han-Michael
Ti: **Quality of Life: Concepts and Measurement**
So: *Social Indicators Research* 19(1):15–23, 1987

This article introduces a number of chapters that describe the different dimensions and aspects of the quality of life of the West German population. The report is organized into the following major themes: subjective well-being (see above reference); living conditions and their assessment; social structure; and socio-politics. (3 references) CH-P

Address for reprint requests: Address unknown.

**REFERENCE NUMBER 18**

Au: Guyatt, Gordon; Walter, Stephen.; Norman, Geoff
Ti: **Measuring Change Over Time: Assessing the Usefulness of Evaluative Instruments**
So: *Journal of Chronic Diseases* 40(2):171–178, 1987

Reliability, the ratio of the variance attributable to true differences among subjects to the total variance, is an important attribute of psychometric measures. However, it is possible for instruments to be reliable, but unresponsive to change; conversely, they may show poor reliability but excellent responsiveness. This is especially true for instruments in which items are tailored to the individual respondent. Therefore, we suggest a new index of responsiveness to assess the usefulness of instruments designed to measure change over time. This statistic, which relates the minimal clinically important difference to the variability in stable subjects, has direct sample size implications. Responsiveness should join reliability and validity as necessary requirements for instruments designed primarily to measure change over time. (23 references) AA

Address for reprint requests: McMaster University, Hamilton, Ontario, Canada L8N 3Z5

REFERENCE NUMBER 19

Au: Hansson, L.; Berglund M.; Ohman R.

Ti: **Individualized Measures of Outcome versus Standardized Rating Scales in Evaluation of In-hospital Psychiatric Treatment: A Methodological Study**

So: *Acta Psychiatrica Scandinavica* 75:275–282, 1987

The differentiating power of two individually related measures of outcome, target complaints and psychiatrists' evaluation of individually defined treatment objectives, were studied in two models of treatment planning, one with and one without active patient participation. Target complaints were measured at admission, after 5 days and at discharge. Treatment objectives were initially defined in written treatment contracts and evaluated at discharge. These measures were compared with patients' selfreported symptoms as well as with independently rated clinical symptoms at admission and discharge. Both target complaints and psychiatrists' evaluation measured improvement during treatment. The differentiating power between the two experimental conditions was, however, much weaker than that of the symptom rating scales. The psychiatrist's evaluations were strongly influenced by state at discharge and only to a minor extent by changes during treatment. It is concluded that symptom rating scales are superior to individualized measures of outcome in studies on a general psychiatric ward, possibly because the patients are fairly homogenous concerning anxiety. (33 references) AA

Address for reprint requests: Department of Psychiatry University Hospital 221 85, Lund, Sweden

REFERENCE NUMBER 20

Au: Hennessy, Catherine Hagan; Shen, John K.M.

Ti: **Sources of 'Unreliability' in Multidisciplinary Team Assessment of the Elderly**

So: *Evaluation Review* 10(2):178–192, 1986

Assessment of functional abilities is a key problem in providing and evaluating longterm health care for the elderly. This study examines reliability issues involved in these measurements performed by a multidisciplinary service team within a geriatric care program. Rater agreement is found to be affected by measurement constraints in the service delivery setting, work roles, and value differences among staff. Target areas for improving standardization of data collection by service providers are indicated. (15 references) AA

Address for reprint requests: On Lok Senior Health Services, San Francisco, California

REFERENCE NUMBER 21

Au: Jellinek, Michael S.; Murphy, J. Michael; Burns, Barbara J.

Ti: **Brief Psychosocial Screening in Outpatient Pediatric Practice**

So: *Journal of Pediatrics* 109(2):371–378, 1986

The Pediatric Symptom Checklist (PSC) is a brief screening questionnaire designed to help pediatricians in busy office practice select children who are likely to have psychosocial difficulties and thus could benefit from further evaluation. We report two preliminary validation studies that indicate that (1) PSC correlates well with the Childhood Behavior Checklist, a longer, well validated questionnaire, and (2) most children referred for psychiatric evaluation score above the PSC cutoff score. Developing a valid and practical psychosocial screening procedure for office practice is methodologically difficult but highly relevant to clinical practice. (30 references) AA

Address for reprint requests: Child Psychiatry Service, Massachusetts General Hospital, Boston, Massachusetts 02114

REFERENCE NUMBER 22

Au: Kaplan, George A.; Seeman, Teresa E.; Cohen, Richard D.; Knudsen, Lisa P.; Guralnik, Jack

Ti: **Mortality among the Elderly in the Alameda County Study: Behavioral and Demographic Risk Factors**

So: *American Journal of Public Health* 77(3):307–312, 1987

We studied the association between behavioral and demographic risk factors and 17-year mortality in members of the Alameda County (California) Study who were 60–94 years of age at baseline. In this age group, increased risk of death is associated with being male, smoking, having little leisure-time physical activity, deviation from moderate weight relative to height, and not regularly eating breakfast. These increased risks were independent of age, race, socioeconomic position, other behavioral risk factors, and baseline physical health status. Further examination of the group aged 70 or more revealed the same patterns of heightened risk. (36 references) AA

Address for reprint requests: Human Population Laboratory, California Department of Health Services, 2151 Berkeley Way, Annex 2, Room 211, Berkeley, California 94704-9980

REFERENCE NUMBER 23

Au: Kaplan, George A.; Roberts, Robert E.; Camacho, Terry C.; Coyne, James C.

Ti: **Psychosocial Predictors of Depression: Prospective Evidence from the Human Population Laboratory Studies**

So: *American Journal of Epidemiology* 125(2):206–220, 1987

The association between status attributes, personal resources, life stress, physical health, and occurrence of depressive symptoms nine years later was assessed by the 1965 Human Population Laboratory survey of a random sample of 6,928 adults in Alameda County, California, and by a subsequent follow-up survey in 1974. In multiple logistic analyses, depressive symptoms at baseline, low education, physical disability or presence of chronic conditions, poor perceived health, personal uncertainty, residential move, job loss, money problems, anomy,and social isolation were independently associated with increased risk of depressive symptoms at the nine-year follow-up. Age, low income, ethnicity, marital status, separation or divorce, and health practices at baseline were unrelated to depressive symptoms. The results underscore both the multifactorial nature of depressive symptoms. These results underscore both the multifactorial nature of depression and the importance of prospective analyses of depressive phenomena. (73 references) AA

Address for reprint requests: Human Population Laboratory, California Department of Health Services, 2151 Berkeley Way, Annex 2, Room 211, Berkeley, California 94704-9980

REFERENCE NUMBER 24

Au: Kay, Stanley R.; Lindenmayer, Jean Pierre

Ti: **Outcome Predictors in Acute Schizophrenia: Prospective Significance of Background and Clinical Dimensions**

So: *Journal of Nervous and Mental Disease* 175(3):152–160, 1987

In a prospective 2-year follow-up of 37 young acute schizophrenics, we examined the predictive significance and relative contribution of historical, genealogical, course, and clinical dimensions. Patients were evaluated multidimensionally at index admission and after 21 to 33 months, at which time 19 cooperated in follow-up involving clinical, functional, psychometric, and objective outcome measures. Multiple regression analysis found that combinations of 3 to 4 index variables significantly predicted 13 of 14 outcome measures, yielding multiple R values between .63 and .93. In total, a set of eight parameters contributed in explaining the outcome variance. The strongest overall predictor of favorable outcome was baseline negative syndrome. Other significant predictors were good pre-morbid school functioning, favorable prior disposition, sudden onset of illness, non-paranoid sub-diagnosis, family history of alcoholism, psychomotor retardation, and depression. Accordingly, a patient's pre-morbid adjustment, course of illness, and presenting clinical profile provided non-overlapping source of outcome prediction. Of these three dimensions, it was proposed that the prognostic significance of the clinical profile may be phase specific, carrying different implications when assessed in the acute versus chronic stage of illness. (42 references) AA

Address for reprint requests: Research and Assessment Unit, Bronx Psychiatric Center, 1500 Water Place, Bronx, New York 10461

**REFERENCE NUMBER 25**

Au: Knesper, David J.; Belcher, Bruce E.; Cross, John G.
Ti: **Preliminary Production Functions Describing Change in Mental Health Status**
So: *Medical Care* 25(3):222–237, 1987

Change in mental health status is analyzed as a function of hours of professional treatment, patient attributes, treatment characteristics, and environmental factors for each of seven clusters of conditions typically seen by psychiatrists, psychologists, or social workers. One of two regression strategies was effective in characterizing the relationship between status change and the input variables for each condition cluster. In each model, initial severity was significantly associated with change in mental health status, and it captured most of the unexplained variance. Provider time was predictive of improvement for only some conditions and providers. On average, mental health services appear to make patients better, but improvement is not terribly impressive. Moreover, the marginal benefits of treatment fall off as the number of contact hours increases. (18 references) AA

Address for reprint requests: University of Michigan, Mental Health Research Institute, 205 Washtenaw Place, Ann Arbor, Michigan 48109

**REFERENCE NUMBER 26**

Au: Levine, Sol
Ti: **The Changing Terrains in Medical Sociology: Emergent Concern With Quality of Life**
So: *Journal of Health and Social Behavior* 28(1):1–6, 1987

This paper is a revision of the address given upon receipt of the Leo G. Reeder Award for Distinguished Scholarship in Medical Sociology. It was presented on September 1, 1986 to the Medical Sociology Section of the American Sociological Association during its Annual Meetings, held in New York City. (30 references) AA

Address for reprint requests: Boston University, University Professor Program, 745 Commonwealth Avenue, Boston, Massachusetts 02215

REFERENCE NUMBER 27

Au: Liang, Jersey; Asano, Hitoshi; Bollen, Kenneth A.; Kahana, Eva F.; Maeda, Daisaku

Ti: **Cross-Cultural Comparability of the Philadelphia Geriatric Center Morale Scale: An American-Japanese Comparison**

So: *Journal of Gerontology* 42(1):37–43, 1987

This study involves an American-Japanese comparison of the factorial structure of the Philadelphia Geriatric Center (PGC) Morale Scale. A model containing 11 of the original PGC Morale Scale items was found to fit both the American and Japanese data adequately. Factorial invariance was analyzed by testing a series of nested hypotheses involving various equivalence constraints. No major differences were found in the 11-item PGC Morale Scale between the American and Japanese data sets. (18 references) AA

Address for reprint requests: Institute of Gerontology, The University of Michigan, 300 North Ingalls, Ann Arbor, Michigan 48109

REFERENCE NUMBER 28

Au: Lichtenstein, Richard; Thomas, J. William

Ti: **Including a Measure of Health Status in Medicare's Health Maintenance Organization Capitation Formula: Reliability Issues**

So: *Medical Care* 25(2):100–110, 1987

Medicare's formula for determining capitation levels for risk-based HMO's, the Adjusted Average Per Capita Cost (AAPCC), has been criticized as a poor basis for establishing payments. Among new adjusting factors suggested for the formula is a measure of beneficiaries' functional health status. The ability of such a measure to improve predictions of Medicare costs has been demonstrated in several studies. In addition to possessing predictive validity, a measure considered for inclusion in the AAPCC must also be reliable. In the paper, the authors examine a measure of functional health status for intra-rater reliability or, equivalently, stability over time. A sample of 1,616 Medicare beneficiaries was surveyed twice—in late 1982 and in January 1984. Using a five-point scale, functional health status scores were calculated for each of the beneficiaries at two points in time. For 68.4% of the sample, functional health scores were unchanged over the year, and second-year scores were within one point of first year scores for 94.3% of the sample. Based on the intra-class correlation coefficient the scores on this functional health scale demonstrated substantial 'to almost perfect' agreement over the 1-year period. (28 references) AA

Address for reprint requests: Department of Health Services Management and Policy, School of Public Health, The University of Michigan, Ann Arbor, Michigan 48109

REFERENCE NUMBER 29

Au: Margolis, Joseph

Ti: **Thoughts on Definitions of Disease**

So: *Journal of Medicine and Philosophy* 11(3):233–236, 1986

The author comments on an article by H. Merskey in the same issue of the journal (see reference below). Among the topics covered in this critique are the relatively easier task of defining physical rather than psychological illness, and the social and personal context specific nature of disease definition. While Merskey calls for a "satisfactory" definition, Margolis argues for a more relaxed approach to disease definition. (1 reference) CH-P

Address for reprint requests: Department of Philosophy, Temple University, Philadelphia, Pennsylvania 19122

REFERENCE NUMBER 30
Au: Merskey, Harold
Ti: **Variable Meanings For the Definition of Disease**
So: *Journal of Medicine and Philosophy* 11(3):215–232, 1986

It is argued that there is no agreed definition of disease. Purely biological definitions are inadequate and combined biological and social definitions are not yet satisfactory. One approach has been to say that what doctors treat is disease. We are uncomfortable with that because we feel it releases people from obligation on a basis of convenience. In practice the weight given to the idea of disease varies according to what it will imply about obligation and privileges. It is suggested that what doctors treat can be accepted as disease provided that we recognize that the significance of disease must vary with circumstances. Those circumstances include the agreement, more or less, of all persons affected when someone is considered to be a patient. The individual must also be competent and not constrained except by his own biological or psychological characteristics. (36 references) AA

Address for reprint requests: London Psychiatric Hospital, 850 Highbury Avenue, Post Office Box 2532, Terminal A, London, Ontario, N6A 4H1, Canada

REFERENCE NUMBER 31
Au: McKinlay, John B.; McKinlay, Sonja M.; Brambilla, Donald J.
Ti: **Health Status and Utilization Behavior Associated with Menopause**
So: *American Journal of Epidemiology* 125(1):110–121, 1987

Since menopause is increasingly implicated in the etiology of some major age-related diseases in women, such as cancer, cardiovascular disease, osteoporosis, and depression, there is a need to understand the epidemiology of this physiologic event which is universal for women. To date, knowledge of menopause is based on a small proportion of self-selecting, predominantly ill women. A stereotype has emerged of the "typical" menopausal woman, who presents a broad range of diffuse symptoms and is a higher utilizer of health care. This prevailing view is contradicted by prospective data gathered over 27 months on a cohort of approximately 2,500 women who are representative of women aged 45–55 years in Massachusetts. It is demonstrated that 1) menopause itself does not cause poorer health status (either physical or psychologic); 2) menopause itself does not cause an increase in utilization behavior; 3) occurrence of a surgical menopause is the primary menopause-related change associated with subsequent perceived health status and utilization behavior, and then only minimally; and 4) almost all the explained variability in health status and utilization behavior outcomes is attributable to prior health status of the respondents and, to a lesser extent, to utilization behavior. These findings underscore the importance of two methodological requirements for future work: 1) representative samples of apparently healthy women; and 2) prospective data which elucidate causeeffect relations. (28 references) AA

Address for reprint requests: American Institutes for Research, Cambridge Research Center, 1100 Massachusetts Avenue, Cambridge, Massachusetts 02138

REFERENCE NUMBER 32
Au: Newcomb, Michael D.; Bentler, P.M.
Ti: **The Impact of Late Adolescent Substance Use on Young Adult Health Status and Utilization of Health Services: A Structural-Equation Model over Four Years**
So: *Social Science and Medicine* 24(1):71–82, 1987

This study examined the impact of adolescent substance use on young adult health status and health service utilization, while controlling for earlier subjective and objective health problems and seeking medical care. Data were obtained from 654 participants when they were in late adolescence and 4 years later when they were young adults. Latent-variable models were used to determine what effect, if any, adolescent drug use had on later health. A second-order factor of general drug use had a small, but significant, influence on decreasing subjective physical hardiness over the 4-year period. However, general drug use was not directly related to later physical symptomatology, subjective health problems, or health service utilization. General cigarette use and amount of cigarette smoking were significantly related to a range of health outcomes including increased psychosomatic symptoms, respiratory symptoms, reporting trouble with health, nights spent in the hospital, and health service utilization, as well as decreased subjective physical hardiness. Early cannabis use decreased later subjective physical hardiness and increased health problems experienced over the 4 years. Hard drug use was associated with increased emergency physician visits during adolescence and increased perceived trouble with health as young adults. Due to the fact that adolescent general drug use decreased subjective physical hardiness over 4 years, it is possible that continued substance use might lead to more serious objective health consequences later in life. (63 references) AA

Address for reprint requests: Department of Psychology, University of California, Los Angeles, California 90024

## REFERENCE NUMBER 33

Au: Newhouse, Joseph P.; Manning, Willard G.; Duan, Naihua; Morris, Carl N.; Keeler, Emmett B.; et al.
Ti: **The Findings of the Rand Health Insurance Experiment: A Response to Welch et al.**
So: *Medical Care* 25(2):157–172, 1987

In responding to the critique by Welch et al., both cost sharing and the Health Maintenance Organization (HMO) were shown to have decreased hospitalizations and health care expenditures compared to free Fee-for-Service (FFS) care at levels described in previous publications. To establish this, it was shown that there were no important biases due to assignment of study participants to different health insurance plans: data on quality of life were used along with demographic information to indicate that there were no significant differences between persons enrolled in the various cost-sharing plans and FFS. Also, there were no biases due to attrition, reporting and methods, or different rates of use of medical care services during the experiment. This rebuttal also addressed several other criticisms by Welch et al. (87 References) CH-P

Address for reprint requests: The Rand Corporation, 1700 Main Street, Santa Monica, California 90406

## REFERENCE NUMBER 34

Au: Olsson, Gunnar; Levin, Lars-Ake; Rehnqvist, Nina
Ti: **Economic Consequences of Postinfarction Prophylaxis with Beta Blockers: Cost Effectiveness of Metoprolol**
So: *British Medical Journal* 294(6568):339–342, 1987

Treatment with certain beta adrenoceptor blocking agents after myocardial infarction reduces mortality and the incidence of reinfarction. Data from a randomized placebo controlled study of the selective beta blocker metoprolol given as secondary prophylaxis were therefore analyzed for the possible cost effectiveness of extending this treatment to the general population of patients with myocardial infarction. Metoprolol 100 mg twice daily and matching placebo were given to 154 and 147 patients, respectively, for three years. During this period drug costs for the beta blocker, digitalis, and diuretics were analyzed as well as costs of readmission for cardiac problems and indirect costs arising from sick leave or early retirement. Active treatment with metoprolol significantly reduced costs of readmission as well as indirect costs. The net effect per patient over the three years was reduction of roughly 19000 kroner. These results suggest that beta blocker treatment given as secondary prophylaxis after myocardial infarction is highly cost effective. (13 references) AA

Address for reprint requests: Department of Medicine, Karolinska Institute, Danderyd Hospital, S-182 88 Danderyd, Sweden

**REFERENCE NUMBER 35**

Au: Orth-Gomer, Kristina; Unden, Anna-Lena
Ti: **The Measurement of Social Support in Population Surveys**
So: *Social Science and Medicine* 24(1):83–94, 1987

There is an increasing interest to include measures of social support in population surveys of chronic disease risk. The choice among a variety of measurement instruments, however, is difficult. We reviewed social support instruments, which were potentially applicable in population studies. Their conceptual framework, their reported predictive capacity and their psychometric properties were compiled and systematically compared. The convenience, clarity and applicability of the social support instruments were tested in a group of health care employees. Two distinct groups of instruments were identified, those describing quantitative aspects of social network and social interaction and those describing functions and adequacy of social support. The former instruments were more easily applicable, questions were more easily and quickly understood and answered. Furthermore, these instruments had been found to predict physical illness in prospective studies. Their psychometric properties, however, were unknown. Qualitative instruments, on the other hand, were found to include questions, not universally applicable to a general population. These instruments were mostly carefully tested for psychometric properties, but their illness predictive capacity was found to be less well examined. Thus, instruments which satisfied all the desirable requirements could not be identified. (48 references) AA

Address for reprint requests: National Institute for Psychosocial Factors and Health, Box 60210, S-104 01 Stockholm, Sweden

**REFERENCE NUMBER 36**

Au: Osberg, J. Scott; McGinnis, Gayle E.; DeJong, Gerben; Seward, Marymae L.
Ti: **Life Satisfaction and Quality of Life Among Disabled Elderly Adults**
So: *Journal of Gerontology* 42(2):228–230, 1987

This paper investigates predictors of life satisfaction and quality of life among severely disabled elderly adults. Markides and Martin's (1979) path analysis model was adapted specifically to elderly persons with severe disabilities. The study group comprised 97 patients discharged from three medical rehabilitation facilities in metropolitan Boston during 1984. The adapted model explained about 40 of the variance in quality of life among both men and women, with functional capacity being the most important predictor. (13 references) AA

Address for reprint requests: New England Medical Center Hospitals, Department of Rehabilitation Medicine, 750 Washington Street, Box 75K/R, Boston, Massachusetts 02111

**REFERENCE NUMBER 37**

Au: Oster, Gerry; Tuden, Rebecca L.; Colditz, Graham A.
Ti: **A Cost-effectiveness Analysis of Prophylaxis Against Deep-Vein Thrombosis in Major Orthopedic Surgery**
So: *Journal of the American Medical Association* 257(2):203–208, 1987

A number of methods of prophylaxis can reduce the likelihood of postoperative deep-vein thrombosis in patients undergoing major orthopedic surgery. Using techniques of decision analysis, we examine the cost-effectiveness of several of these—warfarin sodium, lowdose subcutaneous heparin sodium, graduated compression stockings, intermittent pneumatic compression, heparin plus dihydroergotamine mesylate, and heparin plus stockings—compared with clinical diagnosis and treatment only. Our results show that 153 deaths per 10000 patients occur when no prophylaxis is used: with most prophylaxes, this number is at least halved, and the most effective methods may reduce the number of deaths by three fourths. In addition, all of the prophylaxes considered are cost saving: average costs of care (including prophylaxis costs) are reduced by $19.40 to $181.60 per patient. Prophylaxis against deep vein thrombosis in major orthopedic surgery therefore saves both lives and health care dollars. (77 references) AA

Address for reprint requests: Policy Analysis Inc., 1577 Beacon Street, Brookline, Massachusetts 02146

**REFERENCE NUMBER 38**

Au: Partridge, C.J.; Johnston, M.; Edwards, S.
Ti: **Recovery from Physical Disability after Stroke: Normal Patterns as a Basis for Evaluation**
So: *Lancet I*(8529):373–375, 1987

In 368 patients with residual hemiplegia after stroke, monitoring of recovery over eight weeks showed a distinct time-related pattern. Patterns of this sort could provide useful baselines in various conditions entailing physical disability, allowing comparison of individual scores with the average for that phase of the illness, the setting of precise goals, and the examination of factors that influence recovery. (11 references) AA

Address for reprint requests: Department of Physiology, King's College, London WC2R 2LS England

**REFERENCE NUMBER 39**

Au: Pauker, Stephen G.; Kassirer, Jerome P.
Ti: **Decision Analysis**
So: *New England Journal of Medicine* 316(5):250–258, 1987

In this review, the authors provide a few examples of some advances in the methods and the application of decision analysis. They consider both the advantages of the method and its limitations and offer our thoughts about the extent of the dissemination of decision analysis in medicine. (52 references) AS

Address for reprint requests: The New England Medical Center, 171 Harrison Avenue, Boston, Massachusetts 02111

REFERENCE NUMBER 40
Au: Pollack, Murray M.; Rüttimann, Urs E.; Getson, Pamela R.; et al.
Ti: **Accurate Prediction of the Outcome of Pediatric Intensive Care: A New Quantitative Method**
So: *New England Journal of Medicine* 316(3):134–139, 1987

We surveyed nine pediatric intensive care units (ICUs) to compare patient populations and to test prospectively the hypothesis that differences in mortality rates were due to differences in severity of illness. Age, clinical service, the reason for admission (emergency or scheduled), and the seriousness of the underlying chronic disease were recorded on admission. The severity of illness was assessed on the day of admission with a physiology based measure, the Physiologic Stability Index. The resulting score was used to group patients according to mortality risk. The observed numbers of ICU survivors and non-survivors in each mortality risk group from eight of the pediatric ICUs were compared with the predicted numbers of survivors and non-survivors calculated from a mathematical function (logistic model) derived earlier from data on 822 patients at one of the institutions. Patient populations in the ICUs differed significantly with respect to age (range of medians, 15 to 36 months; $p < 0.0001$), medical admissions (range, 39 to 81 percent; $p < 0.0001$), emergency admissions (range, 53 to 91 percent; $P < 0.0001$), and the percentage of patients with serious underlying chronic disease (range, 18 to 48 percent; $P < 0.0001$). Mortality rates also differed significantly (range, 3.0 to 17.6 percent; $P < 0.0001$), as did the Physiologic Stability Index scores ($P < 0.0001$). The mathematical function based on the Physiologic Stability Index score and on age reliably predicted the outcomes in all ICUs. We conclude that differences in mortality rates among pediatric ICUs can be explained by differences in the severity of illness. (19 references) AA

Address for reprint requests: Pediatric Intensive Care Unit, Children's Hospital National Medical Center, 111 Michigan Ave. N.W., Washington, DC 20010

REFERENCE NUMBER 41
Au: Reker, Gary T.; Peacock, Edward J.; Wong, Paul T.P.
Ti: **Meaning and Purpose in Life and Well-Being: A Life-Span Perspective**
So: *Journal of Gerontology* 42(1):44–49, 1987

Three hundred men and women at five developmental stages from young adulthood to the old-old completed measures of life attitudes and well-being. Significant age differences were found on five life attitude dimension: Life Purpose (LP), Death Acceptance (DA), Goal Seeking (GS), Future Meaning (FM), and Existential Vacuum (EV). LP and DA increased with age; GS and FM decreased with age; EV showed a curvilinear relationship with age. Significant sex differences were found for Life Control (LC) and Will to Meaning (WM). Women viewed life as more under their control and expressed a stronger will to find meaning as compared with males. FM, LP, and LC were found to predict psychological and physical well-being; EV, GS, and DA predicted psychological and physical discomfort. Preliminary findings attest to the importance of various life attitudes in promoting health and wellness. (24 references)AA

Address for reprint requests: Department of Psychology, Trent University, Peterborough, Ontario, Canada K97 7B8

REFERENCE NUMBER 42
Au: Roca, Robert P.
Ti: **Bedside Cognitive Examination**
So: *Psychosomatics* 28(2):71–76, 1987

Delirium and dementia are often overlooked among the elderly ill. Their recognition depends in part on the bedside cognitive, or "sensorial" examination. Individual components of the examination, such as orientation testing, serial sevens and three-object recall, are not sufficiently sensitive or specific to serve as adequate screening tests. However, a number of brief instruments described here, which standardize the administration of several traditional bedside tests, show promise when used in combination form. This article also describes a procedure for analyzing selected responses to provide a combination instrument with still better diagnostic accuracy. (29 references) AA

Address for reprint requests: Department of Psychiatry, Francis, Francis Scott Key Medical Center, 4940 Eastern Avenue, Baltimore, Maryland 21224

REFERENCE NUMBER 43
Au: Rohrer, James E.; Hogan, Andrew J.
Ti: **Modeling the Outcomes of Nursing Home Care**
So: *Social Science and Medicine* 24(3):219–223, 1987

In this exploratory analysis using data on 290 patients, we use regression analysis to model patient outcomes in two Veterans Administration nursing homes. We find resource use, as measured with minutes of nursing time, to be associated with outcomes when case mix is controlled. Our results suggest that, under case based reimbursement systems, nursing homes could increase their revenues by withholding unskilled and psychosocial care and discouraging physicians' visits. Implications for nursing home policy are discussed. (10 references) AA

Address for reprint requests: Graduate Program in Hospital and Health Administration, 2700 Steindler Building, The University of Iowa, Iowa City, Iowa 52242

REFERENCE NUMBER 44
Au: Roos, Leslie L., Jr.; Nicol, J. Patrick.; CaGeorge, Sandra M.
Ti: **Using Administrative Data for Longitudinal Research: Comparisons with Primary Data Collection**
So: *Journal of Chronic Diseases* 40(1):41–49, 1987

This paper discusses the advantages and disadvantages of using administrative data for longitudinal research, focusing on loss to follow-up. Comparisons between research relying on primary data collection and that using data bases are made. After development of a suitable framework, follow-up in several well-known projects based on primary data collection (the Seven Countries project on coronary heart disease, the Massachusetts research on long-term care and the Pittsburgh clinical trial of tonsillectomy) is compared with follow-up using the Health Services Commission data base in Manitoba, Canada. Overall follow-up in the Manitoba research compares favorably with participation and follow-up rates in other studies based on primary data collection. Initial non-response and non-location are major problems with studies using primary data; failure to locate earlier respondents in subsequent waves results in a wide range of overall response rates. Data bases do not require researchers to contact individuals and hence follow-up is simplified. Eight year follow-up rates in the Manitoba data bases are almost always over 80% and often over 90%. Because records can be flexibly summarized for each individual over time, data base facilitate certain types of longitudinal studies which would be difficult, if not impossible, to perform using other methodologies. If the desired data are available and recorded with acceptable accuracy, administrative data banks hold considerable promise for the health care researcher. (60 references) AA

Address for reprint requests: Department of Business Administration University of Manitoba, Winnipeg, Manitoba, Canada R3T 2N2

**REFERENCE NUMBER 45**
Au: Sack, Henry S.; Berrier, Jayne; Reitman, Dinah; Ancona Berk, V.A.; Chalmers, Thomas C.
Ti: **Meta-Analyses of Randomized Controlled Trials**
So: *New England Journal of Medicine* 316(8):450–454, 1987

A new type of research, termed meta analysis, attempts to analyze and combine the results of previous reports. We found 86 meta-analyses of reports of randomized controlled trials in the English-language literature. We evaluated the quality of these meta-analyses, using a scoring method that considered 23 items in six major areas—study design, combinability, control of bias, statistical analysis, sensitivity analysis, and application of results. Only 24 meta-analyses (28 percent) addressed all six areas, 31 (36 percent) addressed five, 25 (29 percent) addressed four, 5 (6 percent) addressed three, and 1 (1 percent) addressed two. Of the 23 individual items, between 1 and 14 were addressed satisfactorily. We conclude that an urgent need exists for improved methods in literature searching, quality evaluation of trials, and synthesizing of the results. (23 references) AA

Address for reprint requests: Clinical Trials Unit, Mount Sinai Medical Center, 1 Gustave L. Levy Place, New York, New York 10029

**REFERENCE NUMBER 46**
Au: Sammartino, Frank J.
Ti: **The Effect of Health on Retirement**
So: *Social Security Bulletin* 50(2):31–47, 1987

This article, which is one of the background papers to the Social Security Amendments of 1983, analyses the influence of health on the timing of retirement. After reviewing the specific effects of the amendments on future retirement benefits, it presents a theoretical model of retirement timing that includes the influence of health and the effects of social security benefits. The author then reviews some recent empirical research on the role of health in the retirement decision, explores how health has been measured in these studies, and reviews the research on health and retirement that has explored differences in the effects of health based on occupation, race, and sex. The final section assess research findings and draws some tentative conclusions. (63 references) AA

Address for reprint requests: Office of Income Security, Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201

**REFERENCE NUMBER 47**
Au: Schroeder, Steven A.
Ti: **Outcome Assessment 70 years Later: Are We Ready?**
So: *New England Journal of Medicine* 316(3):160–162, 1987

This article notes the increasing emphasis on measuring outcomes of health care delivery rather than on process or structure. Although there are problems with some of the measures, for example, crude mortality unadjusted for severity, the attention that the Joint Commission on Accreditation of Hospitals is currently placing on outcome assessment is taken as good news. (10 references) CH-P

Address for reprint requests: University of California at San Francisco, California 94143

## REFERENCE NUMBER 48

Au: Showstack, Jonathan A.; Rosenfeld, Kenneth E.; Garnick, Deborah W.; Luft, Harold S.; Schaffarzick, Ralph W.; et al.
Ti: **Association of Volume with Outcome of Coronary Artery Bypass Graft Surgery**
So: *Journal of the American Medical Association* 257(6):785–790, 1987

Empirical evidence suggests that mortality rates for coronary artery bypass graft (CABG) surgery are lower in hospitals that perform a higher volume of the procedure. In recent years, the criteria for CABG surgery have been expanded to include patients with a wide variety of comorbidities. To address the question of whether the volume-outcome relationship continues to exist for this new group of patients, discharge abstracts for 18,986 CABG operations at 77 hospitals in California in 1983 were analyzed using multiple-regression techniques. Higher-volume hospitals had lower in-hospital mortality (adjusted for case mix); this effect was greatest in patients who might be characterized as having "non-scheduled" CABG surgery. Higher-volume hospitals also had shorter average postoperative lengths of stay and fewer patients with extremely long stays. The results of this study suggest that the greatest improvement of average outcome for CABG surgery would result from the closure of low-volume surgery units. (15 references) AA

Address for reprint requests: Institute for Health Policy Studies, University of California at San Francisco, 1326 Third Avenue, San Francisco, California 94143

## REFERENCE NUMBER 49

Au: Smith, David W.; Hogan, Andrew J.; Rohrer, James E.
Ti: **Activities of Daily Living as Quantitative Indicators of Nursing Effort**
So: *Medical Care* 25(2):120–130, 1987

Functional assessments of elderly or disabled people requiring long-term care have been used by clinicians for many years, and functional assessment instruments are now being used as indicators of required nursing care and its cost. The authors examine the ability of functional assessment items and instruments to measure accurately the variation in nursing care used by nursing home patients, with analysis of 290 patients. Nursing times, measured for each patient by nurse category (registered and all other and type of care (skilled and personal) measure resource consumption. Activities of daily living (ADLs) eating, bathing, dressing, toileting, transferring, and continence are used to measure functional abilities on a four-point scale: independent, supervised assisted or helped, and dependent, a well as two derived scales: Katz's Index and Resource Utilization Groups. The four-point measurement scales for ADLs are found to be necessary as indicators of nursing time required by patients. As a consequence, the three point scales used for ADLs in the Longterm Care Minimum Data Set are not adequate, at least in nursing homes, for resource allocation. The relationship of nursing times with individual ADLs is nonlinear, so linear statistical techniques such as principal components, canonical correlations, or liner regression are inappropriate to produce patient classification systems based on ADLs. Individual ADLs do not explain use of registered nursing care time as well as they do care time by other nursing staff. Therefore, resource allocation and staffing for registered nurses must be done separately from other nursing personnel, using indicators other than ADLs. (11 references) AA

Address for reprint request: Clinical Nursing Research Program, 301 SSH, Rush Presbyterian St. Luke's Medical Center, 1743 W. Harrison, Chicago, Illinois 60612

**REFERENCE NUMBER 50**

Au: Strayhorn, Joseph M.
Ti: **Control Groups for Psychosocial Intervention Outcome Studies**
So: *American Journal of Psychiatry* 144(3):275–282, 1987

In psychosocial outcome research, as contrasted to pharmacologic research, control groups receiving inert treatment, designed to raise expectations but otherwise provide no service are almost never indicated; this is true because of methodologic as well asethical reasons. Four types of comparisons suffice as alternatives: treatment versus no treatment, treatment versus minimal treatment, treatment A versus treatment B, and dismantling. When choices are made among these types of comparisons with power analysis and eight other factors taken into account, the questions of outcome research should be answerable with maximum economic efficiency, with maximum benefit to subjects, and without deception. (28 references) AA

Address for reprint requests: Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, Pennsylvania 15213

**REFERENCE NUMBER 51**

Au: Tosi, Laura L.; Detsky, Allan S.; Roye, David P.; Morden, Mary L.
Ti: **When does Mass Screening for Open Neural Tube Defects in Low-Risk Pregnancies Result in Cost Savings?**
So: *Canadian Medical Association Journal* 136(3):255–265, 1987.

Using a decision analysis model, we estimated the savings that might be derived from a mass prenatal screening program aimed at detecting open neural tube defects (NTDs) in low-risk pregnancies. Our baseline analysis showed that screening versus no screening could be expected to save approximately $8 per pregnancy given a cost of $7.50 for the maternal serum alpha protein (MSAFP) test and a cost of $42507 for hospital and rehabilitation services for the first 10 years of life for a child with spina bifida. When a more liberal estimate of the costs of caring for such a child was used, the savings with the screening program were more substantial. We performed extensive sensitivity analyses, which showed that the savings were somewhat sensitive to the cost of the MSAFP test and highly sensitive to the specificity (but not the sensitivity) of the test. A screening program for NTDs in low-risk pregnancies may result in substantial savings in direct health care costs if the screening protocol is followed rigorously and efficiently. (29 references) AA

Address for reprint requests: Department of Orthopedic Surgery, Children's Hospital National Medical Center, 111 Michigan Ave. N.W., Washington, DC 20010

**REFERENCE NUMBER 52**

Au: Uhlmann, Richard F. Larson, Eric B.; Buchner, David M.
Ti: **Correlations of Mini-Mental State and Modified Dementia Rating Scale to Measure of Transitional Health Status in Dementia**
So: *Journal of Gerontology* 42(1):33–36, 1987

Information regarding the relationships of the Mini-Mental State (MMS) and a modified Dementia Rating Scale (mDRS) to measures of change, that is, "transitional" health status, in dementia would be potentially useful in the evaluation and care of demented patients. In a longitudinal study of demented outpatients, MMS and mDRS at entry and at 1- to 2-year follow-up were significantly correlated with five measures of physician- and advocate-rated transitional health status and change in living arrangement during this interval ($p < .01$). MMS and mDRS at followup also predicted mortality during a subsequent year of follow-up ($p < .01$). Estimated change in MMS and mDRS was significantly correlated with all transition variables, except for MMS and change in living arrangement. These results suggest MMS, mDRS, and estimated change in them reflect these aspects of transitional health status in dementia. (18 references) AA

Address for reprint requests: Division of Gerontology and Geriatric Medicine, ZA-87 Harborview Medical Center, 325 9th Avenue, Seattle, Washington 98104

## REFERENCE NUMBER 53

Au: U'Ren, Richard C.
Ti: **Testing Older Patients' Mental Status: Practical Office-Based Approach**
So: *Geriatrics* 42(3):49–60, 1987

Dementia and depression are among the most common psychiatric disorders in the aged. Their detection can be considerably enhanced if the physician (1) includes in the medical evaluation seven components of a psychiatric nature, giving particular attention to signs and symptoms of dementia and depression, and (2) performs a brief formal mental status examination. (18 references) AA

Address for reprint requests: Department of Psychiatry Oregon Health Sciences University, 3181 SW Sam Jackson Park Road, Portland, Oregon 97201

## REFERENCE NUMBER 54

Au: Van Vliet, Rene C.J.A.; Van Praag, Bernard M.S.
Ti: **Health Status Estimation on the Basis of Mimic Health Care Models**
So: *Journal of Health Economics* 6(1):27–42, 1987

In this paper we propose a new method for deriving health indexes from MIMIC-health care models. This method differs from the traditional approach in that the health indexes are not based on the causes of health but on transformations of the health indicators. These transformations are employed mainly to correct for the effects of variables which do influence the health indicators but not health status, H*, itself, like availability of medical specialists. The estimated parameters of this model and the derived health indexes may be used in future research to collect only those health indicators and related variables which appear to contain relevant information on H*. (27 references) AA

Address for reprint requests: Erasmus University, 3000 DR Rotterdam, The Netherlands

## REFERENCE NUMBER 55

Au: Wan, Thomas T.H.
Ti: **Functionally Disabled Elderly: Health Status, Social Support, and Use of Health Services**
So: *Research on Aging* 9(1):61–78,1987

In order to identify the patterns of health-social services used by impaired elders in the community, it is imperative to examine the relationships among health status, social support, and use of services. The role of social support networks as a mediating factor between psychological symptoms and gerontological health deserves a careful assessment. This study has systematically investigated the use of ambulatory services by 694 elders who had a functionally limiting condition in the Statewide Survey of Older Virginians in 1979. (19 references) AA

Address for reprint requests: Virginia Commonwealth University

**REFERENCE NUMBER 56**
Au: Weinberger, Morris; Hiner, Sharon L.; Tierney, William M.
Ti: **In Support of Hassles as a Measure of Stress in Predicting Health Outcomes**
So: *Journal of Behavioral Medicine* 10(1):19–31, 1987

We investigated the impact of frequently occurring minor stressors (hassles) upon health status in a sample of low-income, elderly persons with osteoarthritis. These individuals are characterized by conditions which are precursors to experiencing stress. Using a modified Hassles scale, we replicated some important findings in a sample demographically distinct from earlier studies on hassles. Specifically, (a) hassles were better predictors of health status than major life change events, and (b) the influence of life change events was indirect, i.e., it increased hassles, which in turn, negatively affected health status. Furthermore, hassles correlated strongly with validated indicators of health status. By replicating earlier studies in a demographically dissimilar sample, and by finding significant correlations between hassles and valid physical health measures, we have strengthened the conceptual development of hassles. (33 references) AA

Address for reprint requests: Regenstrief Institute for Health Care, Fifth Floor, 1001 West Tenth Street, Indianapolis, Indiana 46202

**REFERENCE NUMBER 57**
Au: Welch, Bruce L.; Hay, Joel W.; Miller, Daniel S.; Olsen, Randall J.; Rippey, Robert M.; et al.
Ti: **The Rand Health Insurance Study: A Summary Critique**
So: *Medical Care* 25(2): 148–156, 1987

In this article the authors question whether the differences in health care expenditures and hospital utilization between health insurance plans claimed by The Rand Corporation as a result of the Health Insurance Experiment have been shown. The problems with the Rand reports include: (1) apparent bias in presentation of study results; (2) technical problems with statistical design and interpretation; (3) difficulty in obtaining documentation of reports; and (4) insufficient information in reports to support the conclusions and recommendations. For a response to these and other issues, see the rebuttal by Newhouse that is referenced above. (30 references) CH-P

Address for reprint requests: Joel W. Hay, Hoover Institution, Stanford, California 94305-6010

**REFERENCE NUMBER 58**
Au: Wennberg, John E.; Roos, Noralou; Sola, Loredo; Jaffe, Ross
Ti: **Use of Claims Data Systems to Evaluate Health Care Outcomes**
So: *Journal of the American Medical Association* 257(7):933–936, 1987

Data maintained by medical insurance plans can be used to evaluate the incidence of death and nonfatal complications following medical care, to test hypotheses about the outcomes of care, and to identify hospitals with unusually high or low death rates. These uses are illustrated for prostatectomy, utilizing claims data from the Maine Medicare and Manitoba Health Services Commission files. The study shows important differences in death rates between individual hospitals and higher cumulative probability of reoperation following transurethral compared with open prostatectomy. The advantage of claims data are low cost, ease of patient follow-up over long periods, and the absence of reporting bias. The limitations are the adequacy of the data used to control for patient co-morbidity and the lack of outcome information on functional status. The effective use of claims data for monitoring requires the active participation of physicians in improving the data base and interpreting the findings. (10 references) AA

Address for reprint requests: Department of Community and Family Medicine, Dartmouth Medical School, Hanover, New Hampshire 03756

### Professional Journals Reviewed

Articles cited in the ANNOTATIONS Section have been identified from a set of journals that are routinely reviewed by the Clearinghouse staff. Each new issue is examined for book reviews, current research funding opportunities, and forthcoming conferences as well as relevant articles. Journal titles along with the volume and issue number reviewed for this issue of the Bibliography on Health Indexes are listed below.

ABS-American Behavioral Scientist 30(2–4)
Acta Psychiatrica Scandinavica 75(1–3)
American Economic Review 77(1)
American Journal of Economics and Sociology 46(1)
American Journal of Epidemiology 125(1–3)
American Journal of Orthopsychiatry 57(1)
American Journal of Psychiatry 144(1–3)
American Journal of Psychology 99(4) 100(1)
American Journal of Public Health 77(1–3)
American Journal of Sociology 92(4–5)
American Political Science Review 80(4) 81(1)
American Psychologist 42(1–3)
American Sociological Review 52(1)
Archives of Physical Medicine and Rehabilitation 68(1)
Behavioral Science 32(1)
British Journal of Psychiatry 150(1–3)
British Journal of Psychology 78(1)
British Journal of Sociology 38(1)
British Medical Journal 294(6568–6575)
Canadian Journal of Behavioral Science 19(1)
Canadian Journal of Public Health 78(1)
Canadian Medical Association Journal 136(1–6)
Child Welfare 66(1–2)
Clinical Gerontologist 6(3)
Clinical Psychology Review 7(1–2)
Cognitive Psychology 19(1)
Cognitive Therapy and Research 11(1)
Econometrica 55(1–2)
Economic Development and Cultural Change 35(2)
Evaluation Review 10(2) 10(4–6) 11(1)
Family and Community Health 9(4)
Geriatrics 42(1–3)
Gerontologist 27(1)
Hastings Center Report 171)
Health Affairs 5(4)
Health Care Financing Review 8(1–3)
Health Education Quarterly 13(3) 14(1)
Health Policy 6(4) 7(1)
Health Psychology 6(1)
Health Services Research 21(6)
Health Values 11(1)
Home Health Care Services Quarterly 8(1)
Human Organization 45(4)
International Journal of Aging and Human Development 24(1–2)
International Journal of Epidemiology 16(1)
International Journal of Health Services 17(1)
International Journal of Mental Health 15(4)
Issues of Science and Technology 3(2)
Journal of Accounting and Public Policy 35(1) 35(3)
Journal of Allied Health 16(1)
Journal of Applied Behavioral Science 22(4)
Journal of Applied Psychology 72(1)
Journal of Behavioral Medicine 10(1)
Journal of Chronic Diseases 40(1–3)
Journal of Community Health 11(4)
Journal of Econometrics 33(1/2)
Journal of Epidemiology and Community Health 41(1)
Journal of Experimental Child Psychology 42(1–3) 43(1)
Journal of Experimental Social Psychology 22(6) 23(1–2)
Journal of Gerontology 41(6) 42(1-2)
Journal of Health and Social Behavior 28(1)
Journal of Health Economics 6(1)
Journal of Health, Politics, Policy and Law 11(4)
Journal of Medical Systems 10(4)
Journal of Medicine and Philosophy 11(2–3)
Journal of Nervous and Mental Diseases 174(11–12) 175(1–3)
Journal of Pediatrics 109(2) 110(1–3)
Journal of Policy Analysis and Management 6(1–2)
Journal of Policy Modelling 8(4)
Journal of Political Economy 94(5–6) 95(1)
Journal of Public Health Policy 7(40
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Sociology of Health and Illness 9(1).
Statistics in Medicine 6(1–2)
World Health Forum 8(1)
World Health Statistics Quarterly 40(1)

**Monographs, Government Documents and Unpublished Reports**

The unpublished reports cover work in progress and articles submitted for publication. Monographs, government publications and unpublished reports cited in the ANNOTATIONS Section have been received by the Clearinghouse during the January through March 1987 period. Thus, it is possible for unpublished materials that have been written prior to these months to appear in this issue.

This section lists citations to journal articles which have been classified under the medical subject heading health status indicators' by the National Library of Medicine (NLM) and which were entered into the NLM's SDILINE or FILE HEALTH data bases in January, February, or March 1987. Citations are printed, with only slight modification of format, in the order and form in which they appear in the NLM published in some language other than English. Abstracts are printed when they are available from NLM's database.

**REFERENCE NUMBER 59**
Au: Knox E.G. ; Lancashire R. ; Armstrong E.H.
Ti: **Perinatal mortality standards: construction and use of a health care performance indicator**
So: *J Epidemiol Community Health* 1986 Sep;40(3):193–204

Perinatal mortality rates are an important index of the performance of perinatal health care services, but comparisons are confounded by variations in the prior risk status of the clienteles of different districts and different maternity units. A method of allowing for these differences has been devised. It is based jointly upon the exclusion of certain classes of birth, and on indirect standardisation for birthweight and a number of modifying factors. The method is described, tested, demonstrated, and proposed for more general use.

**REFERENCE NUMBER 60**
Au: Sloss E.M. ; Keeler E.B. ; Brook R.H. ; Operskalski B.H. ; Goldberg G.A. ; Newhouse J.P.
Ti: **Effect of a health maintenance organization on physiologic health**
So: *Ann Intern Med* 1987 Jan;106(1):130-

In a previous comparison of persons between 14 and 62 years of age randomly assigned to receive care through a fee-for-service system (n = 784) or through a health maintenance organization (HMO) (n = 738) in Seattle, Washington, persons in the HMO had much lower hospital expenditures and admissions, more bed days, a higher prevalence of serious symptoms, and less satisfaction with care. We report an examination of 20 additional health status measures. Our results are consistent with a hypothesis of no differences in health status measures between the two systems. In addition, a comparison of nine health practices between the systems also indicated no overall differences. Most physiologic measures and health practices for a typical person were not affected by care received through the fee-for-service system or the HMO. However, we are less certain of this result in specific subgroups, such as persons of lower income initially at elevated risk, because confidence intervals are necessarily wider. We conclude that the cost savings achieved by this HMO through lower hospitalization rates were not reflected in lower levels of health status.

**REFERENCE NUMBER 61**
Au: White V.K.
Ti: **Promoting health and wellness: a theme for the eighties**
So: *Am J Occup Ther* 1986 Nov;40(11):743–8

**REFERENCE NUMBER 62**
Au: Frederiks C.M.
Ti: **[Preventive medical examination in the aged; pros and cons]**
So: *Tijdschr Gerontol Geriatr* 1986 Oct;17(5):205–8

Preventive medical examination in aged people has some disadvantages when executed as a form of screening of the general population. There are almost no diseases to be found in aged persons, which meet the criteria for screening. It is likely that more needless disturbance is caused than actual case-finding achieved. Non-response in aged people will be high. And at last multiple pathology in aged people brings about that the total health-state is more important than the occurrence of specific diseases. These disadvantages can be partly solved by way of pre-selection of high risk aged persons. This increases the predictive value of the diagnostic tests; partly precluding non-response by means of having the first preventive examination at home; and determining the state of health in first instance by asking questions about ADL, house-keeping abilities, state of mental health, nutrition, a.o. The possibility of the community nurse paying home visits in stead of preventive medical examination will be discussed.

REFERENCE NUMBER 63

Au: Danilevicz N. ; Meneghel S.N.
Ti: **[Evaluation of health conditions in Rio Grande do Sul]**
So: *Rev Saude Publica* 1986 Apr;20(2):107–14

REFERENCE NUMBER 64

Au: Schoenborn C.A.
Ti: **Health habits of U.S. adults, 1985: the “Alameda 7” revisited**
So: *Public Health Rep* 1986 Nov-Dec;101(6):571–80

Seven health habits, commonly referred to as the “Alameda 7,” were shown to be associated with physical health status and mortality in a pioneer longitudinal study initiated in 1965 in Alameda County, CA. These habits are having never smoked, drinking less than five drinks at one sitting, sleeping 7–8 hours a night, exercising, maintaining desirable weight for height, avoiding snacks, and eating breakfast regularly. The Alameda study focused attention on the importance of everyday practices for the maintenance of good health and, ultimately, for longer life. This report presents selected findings on the prevalence of the seven Alameda practices (defined slightly differently in some cases) among the general U.S. population aged 18 years and older, by sex, according to age, education, income, and race. In general, men are more likely than women to smoke, drink, and exercise. Younger people are more likely than older people to skip breakfast, snack, and drink, and younger women are more likely than older women to smoke. Education, income, and racial differences were found for most health practices. Of all subgroups discussed, blacks, particularly black women, are the most likely to have lifestyles that would be considered unhealthy using the Alameda criteria. Overall, the data reported suggest that although large numbers of U.S. adults have healthy habits, many do not, particularly persons in socially and economically disadvantaged groups.

REFERENCE NUMBER 65

Au: Albala D.M. ; Qureshi A.F. ; Karim M.S. ; De Sa H. ; Tousignant P. ; Bryant J.H.
Ti: **A comparison of health and socioeconomic indicators in the townships of Orangi and Karimabad**
So: *JPMA* 1986 Sep;36(9):21885

REFERENCE NUMBER 66

Au: Robinson B.E. ; Lund C.A. ; Keller D. ; Cuervo C.A.
Ti: **Validation of the Functional Assessment Inventory against a multidisciplinary home care team.**
So: *J Am Geriatr Soc* 1986 Dec;34(12):851–4

Systematic multidimensional assessment techniques such as the Functional Assessment Inventory (FAI) are increasingly used with the elderly for outcome measurement, prediction of service needs, and accurate description for comparative purposes. The FAI is a structured interview followed by a rating process which compares patient status against Standard descriptive phrases. Patients are assessed in five areas: mental health, physical health, social resources, economic resources, and activities of daily living (ADL). The validity of the FAI was tested by comparing ratings of patient health obtained by a single investigator using only the instrument with ratings obtained by consensus from an interdisciplinary home care team providing long-term care for the patients studied. An excellent level of agreement (weighted kappas from .583 to .780) was found in all areas studied. A single significant difference in ADL rating with a high correlation coefficient (r = .85) was interpreted as due to a difference between the single rater and the team in the definition of ADL. The ease of obtaining summary ratings from clinical personnel suggests that further exploration of this rapid quantification of patient health is warranted.

**REFERENCE NUMBER 67**
Au: Schwalbe M.L. ; Staples C.L.
Ti: **Class position, work experience, and health**
So: *Int J Health Serv* 1986;16(4):583–602

This paper develops a Marxist analysis of the relationships between class position, work experience, the psychological effects of this experience, and subsequent health outcomes. Specifically, it is argued that the structural imperatives of capitalist production make work for those in working-class positions subject to greater routinization and less control than work for those in other class positions. Routinization and control are argued, in turn, to predictably affect two key psychological variables, self-esteem and stress, which are further argued to affect health in predictable ways. Position in the capitalist labor process is thus linked to health via the psychological consequences of the immediate work experience it engenders. Survey data from workers, managers, supervisors, and semi-autonomous employees in five capitalist firms are used to test the descriptive adequacy of this model linking capitalism to ill health for those in working-class positions.

**REFERENCE NUMBER 68**
Au: Izmailova G.D. ; Derevianko L.D.
Ti: **[Hygienic characteristics of working conditions and the functional status of technicians in agricultural aviation]**
So: *Gig Tr Prof Zabol* 1986 Sep;(9):27–30

**REFERENCE NUMBER 69**
Ti: Current estimates from the National Health Interview Survey. United States, 1983
So: *Vital Health Stat* [10] 1986 Jun;(154):1–182

**REFERENCE NUMBER 70**
Au: Wagstaff L. ; de Vries G.
Ti: **Children's growth charts in theory and practice**
So: *S Afr Med J* 1986 Sep 27;70(7):426–7

The many advantages accruing from the use of children's growth charts are briefly outlined. Simple small studies are described to assess how this health care tool is being utilized in Soweto. The results provide some evidence that this reputedly simple technique might be yet more effectively used.

### REFERENCE NUMBER 71

Au: Cameron N.
Ti: **Standards for human growth—their construction and use**
So: *S Afr Med J* 1986 Sep 27;70(7):422–5

Human growth charts are used in the RSA to monitor the growth of groups of children and of individual. Ignorance of their construction leads to misunderstandings of their correct application. The construction and use of growth charts is reviewed by explaining how growth may be investigated through cross-sectional, longitudinal and mixed-longitudinal studies and the problems involved in using the subsequent data. The intellectual confusion brought about by describing such charts as 'standards' and how the most appropriate chart for South Africa should be defined is also discussed. Finally, the priorities for research in this field are outlined.

### REFERENCE NUMBER 72

Au: Ovcharov V.K.
Ti: **[Status and developmental prospects in social hygiene research]**
So: *Sov Zdravookhr* 1986;(8):3–9

### REFERENCE NUMBER 73

Au: Lundberg O.
Ti: **Class and health: comparing Britain and Sweden**
So: *Soc Sci Med* 1986;23(5):511–7

The questions addressed in this article are two, namely are class differences in health apparent in Swede in the same manner as was shown for Britain in the Black Report? and is it possible to learn anything new about inequality patterns in different stages of life from analyses of self-reported morbidity data? By analysing data on long-standing illness by the means of logistic regression, it is shown that the risk of falling ill is distributed in very similar ways in the two countries, although the dispersion of these risk factors seems to be greater in Britain. In an analysis of acute sickness this result is not obtained, which is assumed to be an effect of differences in answering patterns. For Sweden, it is shown that social classes do not differ much in terms of health among the young. Instead, inequalities in health seem to be established at first in middle age.

### REFERENCE NUMBER 74

Au: Osin AIa
Ti: **[Hematological criteria of the reactivity of children of health group I in the system of general mass screening**
So: *Pediatriia* 1986 Aug;(8):8–11

### REFERENCE NUMBER 75

Au: Spitzer W.O. ; Suissa S. ; Eastridge L. ; Shenker S. ; Germanson T. ; Murdie R.A.; MacPherson A.S
Ti: **The Toronto Junction Triangle Health Study: a response to a community health emergency.**
So: *Can J Public Health* 1986 Jul-Aug;77(4):256–62

REFERENCE NUMBER 76

Ti: **National Institutes of Health Consensus Development Conference statement: health implications of smokeless tobacco use. January 13–15, 1986**

So: *CA* 1986 Sep-Oct;36(5):310–6

REFERENCE NUMBER 77

Au: Behr W. ; Herrmann U.

Ti: **[The total character of health]**

So: *Z Arztl Fortbild* (Jena) 1986;80(15):645–7

REFERENCE NUMBER 78

Ti: **Current estimates from the National Health Interview Survey. United States, 1984**

So: *Vital Health Stat* [10] 1986 Jul;(156):1–191

REFERENCE NUMBER 79

Au: Balaban D.J. ; Sagi P.C. ; Goldfarb N.I. ; Nettler S.

Ti: **Weights for scoring the quality of well-being instrument among rheumatoid arthritics. A comparison to general population weights**

So: *Med Care* 1986 Nov;24(11):973–80

The importance of measuring health outcomes such as functional status and quality of life has increased with the greater emphasis on efficiency and on judgements of clinical effectiveness of therapies for patients with chronic disease. One measure of health status, the quality of well-being (QWB), has received significant attention as a health policy model because it quantifies health on a scale ranging from "zero" (death) to "one" (optimal health). The scale is based on weights (values) that were derived by having several thousand individuals in the general population rate scenarios in which a patient is described in terms of mobility, physical activity, social activity, and major symptom or problem. The present study was undertaken to determine if a disease-specific population composed of patients with moderate and moderately severe rheumatoid arthritis who were participating in a national multicenter trial of a new oral therapeutic agent, would rank scenarios similarly to the general population sample. In this study, close agreement was found between the weights obtained from the general population sample and the weights obtained from the sample of rheumatoid arthritic patients (R = 0.937). The investigators believe that the study supports the use of the original general population weights and suggest that the index may be used for populations with a specific condition as well as for general populations.

### American Medical Review Research Center's Symposium
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Papers dealing with the following topics will be presented:
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- medical quality information for consumers
- research and application studies on uniform clinical databases
- models for or applications of quality assessment tools in non-acute settings: long term, ambulatory, home health
- corporate quality assessment programs

For further information contact

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### American Public Health Association
### Boston, Massachusetts 13–17 November 1988

The theme for this year's annual meeting is "Technology and Health: Problems and Promises." The meeting is expected to consist of a number of sessions of interest to persons working in the area of health status and quality of life assessment.

On Wednesday afternoon, 16 November, there will be a session entitled "National Data for Measuring Health and Quality of Life." The first half of this session will present current activities in measuring health-related quality of life that are underway at the National Center for Health Statistics (NCHS) and the National Heart, Lung and Blood Institute. The second half will discuss future directions being considered by NCHS and the National Institutes of Health.

## Clearinghouse Update

Over the next few months the Clearinghouse staff will be devoting its energies to bringing the Bibliography on Health Indexes series up to date. To do this as expeditiously as possible, sections other than the Annotations and Selections from NLM may be somewhat shorter than in some of the previous issues. When the Bibliography is once agian current, the news sections will once again be expanded as resources permit. The Clearinghouse thanks everyone for his or her patience.

### Why "Indexes"?

In the health field the terms "index" and "indicator" have been used interchangeably when the primary measure of health status was a single measure such as a mortality rate or life expectancy. More recently, however, research efforts have focused on developing composite measures which reflect the positive side of health as well as changing disease and death patterns. Progress is being made; and the resultant health status measures are being applied. Although the measures have become more complex, the terms "index" and "indicator" are still used interchangeably. In providing information to assist in the development of composite health measures, the Clearinghouse has adopted the following definition: a health index is a measure which summarizes data from two or more components and which purports to reflect the health status of an individual or defined group.

### Why a "Clearinghouse"?

It has become apparent that different health indexes will be necessary for different purposes; a single GNP-type index is impractical and unrealistic. Public interest coupled with increased government financing of health care has brought new urgency for health indexes. Their development can be hastened through active communications; the Clearinghouse was established to provide a channel for these communications.

### What's Included?

The selection of documents for the Clearinghouse focuses on efforts to develop and/or apply composite measures of health status. A reprint or photocopy of each selection is kept on file in the Clearinghouse. Domestic and foreign sources of information will include the following types of published and unpublished literature: articles from regularly published journals; books, conference proceedings, government publications, and other documents with limited circulation; speeches and unpublished reports of recent developments; and reports on grants and contracts for current research. The Clearinghouse will systematically search current literature and indexes of literature to maintain an up-to-date file of documents and retrospectively search to trace the development of health indexes. Specifically, items will be included if they:

1. advance the concepts and definitions of health status by
   a) operationalizing the definition
   b) deriving an algorithm for assigning weights
   c) computing transitional probabilities
   d) validating new measures

2. use composite measure(s) for the purpose of
   a) describing or comparing the health status of two or more groups
   b) evaluating a health care delivery program

3. involve policy implications for health indexes

4. review the "state of the art"

5. discuss a measure termed "health index" by the author

### What Services?

The Clearinghouse publishes the *Bibliography on Health Indexes* four times each year. This compilation consists of citations of recent reprints or photocopies included in the Clearinghouse file of documents. Each citation in the ANNOTATIONS Section will be followed by a brief summary of the article. The period covered and the sources used in the compilation will be clearly stated in each issue. At present, the

Bibliography, its abstracts and other notes are all printed in English. Also presented in the Bibliography is information about forthcoming conferences, notification of publication of previously cited forthcoming materials, new information sources, etc. Addresses of contributors and sponsoring organizations for conferences are given in each Bibliography. Readers should contact the authors directly to request reprints or to discuss particular issues in greater detail.

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