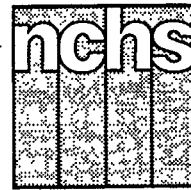


Clearinghouse on Health Indexes



National Center for Health Statistics

Bibliography on Health Indexes

2 ACKNOWLEDGMENTS

3 ANNOTATIONS

3 Battaglia, Angelo; Bruni, Giancarlo; Ardia, Alfredo; Sacchetti, Gabriele; Nicergoline in Mild to Moderate Dementia: A Multicenter, Double-Blind, Placebo-Controlled Study; *Journal of the American Geriatrics Society* 37(4):295-302, 1989

3 Bonardi, Elisa; Pencer, Irwin; Tourigny-Rivard, Marie-France; Observed Changes in the Functioning of Nursing Home Residents After Relocation; *International Journal of Aging and Human Development* 28(4):295-304, 1989

4 Branch, Laurence G.; Horowitz, Amy; Carr, Cheryl; The Implications for Everyday Life of Incident Self-Reported Visual Decline Among People Over Age 65 Living in the Community; *Gerontologist* 29(3):359-365, 1989

4 Brennan, Penny L.; Moos, Rudolf H.; Lemke, Sonne; Preferences of Older Adults and Experts for Policies and Services in Group Living Facilities; *Psychology and Aging* 4(1):48-56, 1989

4 Cox, James C.; Epstein, Seth; Preferences Reversals Without the Independence Axiom; *American Economic Review* 79(3):408-426, 1989

5 Deppe, Hans-Ulrich; State and Health; *Social Science and Medicine* 28(11):1159-1164, 1989

5 Eddy, David M.; The Confidence Profile Method: A Bayesian Method for Assessing Health Technologies; *Operations Research* 37(2):210-228, 1989

5 Fabian, Ellen S.; Work and the Quality of Life; *Psychosocial Rehabilitation Journal* 12(4):39-49, 1989

6 Frank, Robert H.; Frames of Reference and the Quality of Life; *American Economic Review* 79(2):80-85, 1989

6 Frank, Robert H.; If Homo Economicus Could Choose His Own Utility Function, Would He Want One With a Conscience? Reply; *American Economic Review* 79(3):594-596, 1989

(continued on page 42)



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control
National Center for Health Statistics
Manning Feinleib, M.D., Dr. P.H., Director

CDC

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 bibliography 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.

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 April, May, or June 1989. Materials searched in the preparation of this issue are given in the section entitled Sources of Information which follows the annotations section. Bibliographic citations are given in the standard form: author, title, and source of the article, designated 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, AS; (3) the author abstract or summary modified by Clearinghouse personnel, AA-M or AS-M; and (4) the Clearinghouse abstract, CH-P, where the initial following the "-" indicates the individual responsible for the abstract.

Copies of items cited in 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: Battaglia, Angelo; Bruni, Giancarlo; Ardia, Alfredo; Sacchetti, Gabriele
 Ti: **Nicergoline in Mild to Moderate Dementia: A Multicenter, Double-Blind, Placebo-Controlled Study**
 So: *Journal of the American Geriatrics Society* 37(4):295-302, 1989

In view of some controversies still existing about the real efficacy of ergot derivatives in the management of dementia, a double-blind, randomized, parallel group trial extending up to 6 months was carried out to compare the effects of nicergoline, 60 mg daily, and placebo in 315 patients suffering from mild to moderate dementia. Clinical evaluation was performed by the SCAG scale. The trial, which included a 1-month placebo run-in period, showed that both placebo and nicergoline were associated with some degree of improvement. The effect of nicergoline, however, was significantly greater and more sustained, steadily increasing with time. In particular, the difference between nicergoline and placebo in mean total SCAG score was 5.5 at 3 months (95% confidence interval: 3.6-7.4) and increased to 9.8 at 6 months (95 percent confidence interval: 7.8-11.8). A comparison of nicergoline versus placebo in the frequencies of changes in each item of the SCAG showed also a significant difference at 6 months, the percent of patients displaying an improvement by at least 2 points ranging from 13.5 (bothersome) to 30.2 (disorientation) in the nicergoline group, against 4.1 (self-care) to 14.3 (fatigue) in the placebo group. The safety of nicergoline, as judged by hemodynamic changes and drug-related adverse reactions, was quite satisfactory. (32 references) AA

Address for reprint requests: Medical Department, Farmitalia Carlo Erba, Via Carlo Imbonati 24, 20159 Milan, Italy

REFERENCE NUMBER 2

Au: Bonardi, Elisa; Pencer, Irwin; Tourigny-Rivard, Marie-France
 Ti: **Observed Changes in the Functioning of Nursing Home Residents After Relocation**
 So: *International Journal of Aging and Human Development* 28(4):295-304, 1989

This study investigated the effects of environmental changes on the functioning of nursing home residents who were relocated to a newly built facility. Assessment via a multidimensional observation scale revealed that the physical functioning and orientation of the relocated residents were not affected. A stabilizing effect on mood was noted along with a relative increase in withdrawn behavior. Mortality rate showed a

decline. These apparent positive and negative effects are discussed in relation to the conditions surrounding the move, the extent of change, and the relative quality of the new environment. (15 references) AA

Address for reprint requests: Geriatric Psychiatry Services, Royal Ottawa Hospital, Ottawa, Ontario, Canada

REFERENCE NUMBER 3

Au: Branch, Laurence G.; Horowitz, Amy; Carr, Cheryl

Ti: **The Implications for Everyday Life of Incident Self-Reported Visual Decline Among People Over Age 65 Living in the Community**

So: *Gerontologist* 29(3):359-365, 1989

The authors examined the consequences of incident self-reported vision loss among a cohort of community-living people aged 66 years and older. Those with visual decline were older than those reporting constant excellent or good vision, but not differing in any other demographic characteristic, the use of formal support services, the use of health services, or ADL (activities of daily living) functioning. Controlling for age and sex, vision loss was associated with unmet instrumental ADL needs such as housekeeping, grocery shopping, and food preparation, and with physical and emotional disabilities. The authors discuss the implication of these disabilities in terms of the challenges to the aging and blindness services delivery systems. (43 references) AA

Address for reprint requests: Boston University School of Public Health and Gerontology Center, 67 Bay State Road, Boston, Massachusetts 02215

REFERENCE NUMBER 4

Au: Brennan, Penny L.; Moos, Rudolf H.; Lemke, Sonne

Ti: **Preferences of Older Adults and Experts for Policies and Services in Group Living Facilities**

So: *Psychology and Aging* 4(1):48-56, 1989

The Policy and Program Information Form-Ideal Form (POLIF-I) was developed to assess preferences of older adults for the policies and services of group-living facilities. Compared with older community residents ($n = 205$), congregate apartment residents ($n = 229$) prefer facilities that have higher behavioral standards, deemphasize supportive services and formal avenues for resident influence, and emphasize privacy. In contrast to older respondents, experts ($n = 44$) prefer settings with lower behavioral standards, more supportive services, more resident input, and more privacy. Sociodemographic characteristics (marital status, occupation, education, age, gender) and functional ability are weakly associated with the policy and service preferences of older respondents. The POLIF-I has several applications, including examination of the congruence between residents' preferences and the actual policies and services of group-living facilities. (18 references) AA

Address for reprint requests: Social Ecology Laboratory, 116-A4, Veterans Administration Medical Center, 3801 Miranda Avenue, Palo Alto, California 94304

REFERENCE NUMBER 5

Au: Cox, James C.; Epstein, Seth

Ti: **Preferences Reversals Without the Independence Axiom**

So: *American Economic Review* 79(3):408-426, 1989

The preference reversal phenomenon was believed to be inconsistent with the transitivity axiom of decision theory. However, recent papers have demonstrated that previously observed preference reversals could be explained by subject violations of the independence axiom or the compound lottery axiom. The

present paper reports the results of experiments in which a substantial proportion of subject responses violate the asymmetry axiom. These results are inconsistent with expected utility theory and its generalizations. (19 references) AA

Address for reprint requests: Department of Economics, University of Arizona, Tucson, Arizona 85721

REFERENCE NUMBER 6

Au: Deppe, Hans-Ulrich

Ti: **State and Health**

So: *Social Science and Medicine* 28(11):1159-1164, 1989

This paper examines the health functions of the state in the F.R.G. in their historical, political, and socioeconomic interrelationships. The main focus is on the antagonistic interests of the social classes. Special emphasis is placed on an analysis of the health political state intervention of 1974 which marked the beginning of the far-reaching economic crisis. There were serious restrictions placed on utilization such as copayments and other interventions: commercialization; privatization; individualization; and the rationalization of public services. Moreover, as the data show, there have been massive transferences within the public service system at the expense of the socially insured. (7 references) AA

Address for reprint requests: Abt. fur Medizinische Soziologie, Theodor-Stern-Kai 7, 6000 Frankfurt/M. 70, Germany

REFERENCE NUMBER 7

Au: Eddy, David M.

Ti: **The Confidence Profile Method: A Bayesian Method for Assessing Health Technologies**

So: *Operations Research* 37(2):210-228, 1989

The Confidence Profile Method is a Bayesian method for adjusting and combining pieces of evidence to estimate parameters, such as the effect of health technologies on health outcomes. The information in each piece of evidence is captured in a likelihood function that gives the likelihood of the observed results of the evidence as a function of possible values of the parameter. A posterior distribution is calculated from Bayes formula as the product of the likelihood function and a prior distribution. Multiple pieces of evidence are incorporated by successive applications of Bayes formulas. Pieces of evidence are adjusted for biases internal or external validity by modeling the biases and deriving "adjusted" likelihood functions that incorporate the models. Likelihood functions have been derived for one-, two-, and multi-arm prospective studies; 2 x 2, 2 x n, and matched case control studies; and cross-sectional studies. Biases that can be incorporated in likelihood functions include crossover in controlled trials, error in measurement outcomes, patient selection biases, differences in technologies, and differences in length of followup. Effect measures include differences of rates, ratios of rates, and odds ratios. The elements of the method are illustrated with an analysis of the effect of a thrombolytic agent on the difference in probability of 1-year survival after a heart attack. (21 references) AA

Address for reprint requests: Duke University, Durham, North Carolina 27706

REFERENCE NUMBER 8

Au: Fabian, Ellen S.

Ti: **Work and the Quality of Life**

So: *Psychosocial Rehabilitation Journal* 12(4):39-49, 1989

Although work has always been a central component of psychiatric rehabilitation, few studies have examined the effect of work on the lives of individuals with psychiatric disabilities. The current study

assessed the impact on work status of quality of life experiences of working and nonworking members of community rehabilitation programs in Maryland. While there was no significant difference between the two groups on the basis of work status alone, gender and race appear to mediate the relationship between employment and quality of life indicators. Results suggest the need to focus on the differential impact of employment of subgroups of the psychiatrically disabled population. (38 references) AA

Address for reprint requests: Department of Human Services, George Washington University, Washington, D.C. 20006

REFERENCE NUMBER 9

Au: Frank, Robert H.

Ti: **Frames of Reference and the Quality of Life**

So: *American Economic Review* 79(2):80-85, 1989

The neoclassical economic model abstracts from context, saying that utility depends only on the level of consumption. This narrow focus misses something important. To predict people's behavior, to draw inferences about their Well-Being, or to make intelligent policy decisions, we must not only know the relevant levels of consumption, but also have an appropriate frame of reference within which to evaluate them. The consumer's frame of reference is discussed in terms of the implications for positive economic analysis, normative analysis, and policy. (18 references) CHI-P

Address for reprint requests: Professor of Economics, Cornell University, Ithaca, New York 14853

REFERENCE NUMBER 10

Au: Frank, Robert H.

Ti: **If *Homo Economicus* Could Choose His Own Utility Function, Would He Want One With a Conscience? Reply**

So: *American Economic Review* 79(3):594-596, 1989

In this article the author argues that the existence of a signal will identify some individuals as honest with certainty. Others have argued that without this assumption, honest individuals have difficulty invading a population initially dominated by defectors. Using the prisoner's dilemma, the author illustrates that it is possible to identify some individuals as honest, although it may not be possible to say with certainty that any given individual is honest. (6 references) AA

Address for reprint requests: Professor of Economics, Cornell University, Ithaca, New York 14853

REFERENCE NUMBER 11

Au: Frankl, David; Oye, Robert K.; Bellamy, Paul E.

Ti: **Attitudes of Hospitalized Patients Toward Life Support: A Survey of 200 Medical Inpatients**

So: *American Journal of Medicine* 86(6):645-648, 1989

Life-support decisions have profound medical, ethical, and economic implications; yet little is known about inpatients' preferences for life-sustaining treatments. This motivated the authors to conduct a prospective survey of medical inpatients to determine attitudes toward life support under differing medical outcomes, and the extent of physician communication about these issues. Each of the 200 adult patients completed a standardized 13-item questionnaire. Patients rated their agreement with life-support treatment in the context of four outcome scenarios. A five-point Likert scale for each question was used, and an overall life-support scale was created by summing the four items. Life support was desired in 90 percent of the patients if their health could be restored to its usual level, in 30 percent if they would be unable to care for themselves after discharge, in 16 percent if their chance for recovery was hopeless, and in only 6 percent if they would remain in a vegetative state. Hospitalized medical patients base their preferences for

life support upon perceived outcomes. The authors encourage physicians to offer their patients discussion about prognosis and treatment efficacy so that disproportionate treatments can be avoided. (16 references) AA

Address for reprint requests: Department of Medicine, Division of General Internal Medicine and Health Services Research, UCLA School of Medicine, Los Angeles, California 90024-1685

REFERENCE NUMBER 12

Au: Fries, James F.

Ti: **The Compression of Morbidity: Near or Far?**

So: *Milbank Quarterly* 67(2):208-232, 1989

The compression-of-morbidity thesis postulates that (a) if the morbid period is defined as that period from the onset of chronic infirmity until death, and (b) if the time of occurrence of such morbid events can be postponed, and (c) if adult life expectancy is relatively constant, then (d) morbidity will be compressed into a shorter period of time. The compression-of-morbidity model suggests a strategy to reduce national morbidity. Years of healthy life may be gained by focusing efforts on moving the onset of first chronic disease upward. Even if total morbidity is not decreased, the rate of increase in morbidity will be slowed. Moreover, the behavioral and preventive initiatives required are relatively low in technological content and may prove to be less expensive than traditional medical approaches. (59 references) AA

Address for reprint requests: Department of Medicine, Stanford University School of Medicine, HRP Building, Room 109, Stanford, California 94305

REFERENCE NUMBER 13

Au: Froberg, Debra G.; Kane, Robert L.

Ti: **Methodology for Measuring Health-State Preferences — I: Measurement Strategies**

So: *Journal of Clinical Epidemiology* 42(2):345-354, 1989

Values play a critical part in decisionmaking at both the individual and policy levels. Numerous methodologies for determining the preferences of individuals and groups have been proposed, but agreement has not been reached regarding their scientific adequacy and feasibility. This is the first of a four-part series of papers that analyze and critique the state-of-the-art in measuring preferences, particularly the measurement of health-state preferences. In this first paper we discuss the selection of relevant attributes to comprise the health-state descriptions, and the relative merits of three measurement strategies: Holistic, explicitly decomposed, and statistically inferred decomposed. The functional measurement approach, a statistically inferred decomposed strategy, is recommended because it simultaneously validates the process by which judges combine attributes, the scale values they assign to health states, and the interval property of the scale. (26 references) AA

Address for reprint requests: University of Minnesota, School of Public Health, Box 197 UMHC, 420 Delaware Street S.E., Minneapolis, Minnesota 55455

REFERENCE NUMBER 14

Au: Froberg, Debra G.; Kane, Robert L.

Ti: **Methodology for Measuring Health-State Preferences — II. Scaling Methods**

So: *Journal of Clinical Epidemiology* 42(5):459-471, 1989

This paper begins with a discussion of measurement principles relevant to determining health-state preferences. Six scaling methods are described and evaluated on the basis of their reliability, validity, and feasibility. They are the standard gamble, time tradeoff, rating scale, magnitude estimation, equivalence, and willingness-to-pay methods. Reliability coefficients for most methods are acceptable, although the low

coefficients for measurements taken a year apart suggest that preferences change over time. Convergent validity among methods has been supported in some but not all studies, and there are limited data supporting hypothetical relationships between preferences and other variables. The category ratings method is easiest to administer and appears to yield valid scale values; thus, it is recommended for large-sample studies. However, decision-oriented methods, particularly the time tradeoff and standard gamble, may be more effective in small-scale investigations and individual decisionmaking. (52 references) AA

Address for reprint requests: University of Minnesota, School of Public Health, Box 197 UMHC, 420 Delaware Street S.E., Minneapolis, Minnesota 55455

REFERENCE NUMBER 15

Au: Froberg, Debra G.; Kane, Robert L.

Ti: **Methodology for Measuring Health-State Preferences—III: Population and Context Effects**

So: *Journal of Clinical Epidemiology* 42(6):585–592, 1989

In addition to the scaling methods, there are many other aspects of the measurement process that may affect rater judgments of the relative desirability of health states. Although we find little compelling evidence of population differences in preferences due to demographic characteristics, there is some evidence suggesting that medical knowledge and/or experience with illness may influence raters' valuations of health states. Other aspects of the rating process that affect rater judgments can be classified as one of two types: Inconsistencies due to limitations in human judgment, and inconsistencies due to situation-specific variables. When inconsistencies are due to limitations in human judgment, such as framing effects, a reasonable solution is to help the rater to see and correct the inconsistency. When inconsistencies are due to situation-specific variables, such as the way the health state is defined and presented, investigators should attempt to standardize conditions across studies. (30 references) AA

Address for reprints requests: Division of Human Development and Nutrition, School of Public Health, University of Minnesota, Minneapolis, Minnesota, 55455

REFERENCE NUMBER 16

Au: Gelberg, Lillian; Linn, Lawrence S.

Ti: **Psychological Distress Among Homeless Adults**

So: *Journal of Nervous and Mental Disease* 177(5):291–295, 1989

Recent studies have reported a high prevalence of mental illness among the homeless. As part of a community-based survey of 529 homeless adults, we developed and tested a model to increase our understanding of the factors related to their psychological distress. Using a previously validated and reliable scale of perceived psychological distress we found that homeless adults were more likely to report psychological distress than the general population (80 percent vs. 49 percent). Distress levels were not associated with most demographic or homeless characteristics or general appearance. However, distress was related to unemployment, greater cigarette and alcohol use, worse physical health, fewer social supports, and perceived barriers to obtaining needed medical care. Since mental, physical, and social health are strongly related among homeless adults, alleviating distress among them may be most effectively done by implementing a broad-based health services package coupled with employment programs provided in an accessible service delivery setting. (21 references) AA

Address for reprint requests: Division of Family Medicine, University of California at Los Angeles, Los Angeles, California 90024

REFERENCE NUMBER 17

Au: Guralnik, Jack M.; Kaplan, George A.

Ti: **Predictors of Healthy Aging: Prospective Evidence From the Alameda County Study**

So: *American Journal of Public Health* 79(6):703-708, 1989

Long-term predictors of high levels of physical functioning were examined in a representative sample of Alameda County, California, residents followed from 1965 through 1984. The cohort investigated in this study was born between 1895 and 1919, with survivors being age 65 to 89 years at the time of followup. A scale of physical functioning was developed from a comprehensive set of questionnaire items which assessed the full spectrum of physical functioning. Those scoring in the top 20 percent, defined as healthy aging, were compared with the remainder of the cohort, including those who died and those with lower levels of functioning at followup. After adjustment for age and functional status at baseline, the following variables were predictive of high functioning at followup 19 years later: Race (those who were not black persons), higher family income level, absence of hypertension, absence of arthritis, absence of back pain, being a nonsmoker, having normal weight, and consuming moderate amounts of alcohol. Sex did not predict high function because of the counterbalancing effects of higher survival in females but greater likelihood of high functioning among surviving males. (26 references) AA

Address for reprint requests: National Institute on Aging, Federal Building, Room 612, 7550 Wisconsin Avenue, Bethesda, Maryland 20892

REFERENCE NUMBER 18

Au: Guyatt, Gordon H.; Deyo, Richard A.; Charlson, Mary; Levine, Mark N.; Mitchell, Alba

Ti: **Responsiveness and Validity in Health Status Measurement: A Clarification**

So: *Journal of Clinical Epidemiology* 42(5):403-408, 1989

The authors present data from two studies which clarify the relationship between the responsiveness and validity of instruments designed to measure in clinical trials. In a controlled trial of long vs. short duration adjuvant chemotherapy for women with Stage II breast cancer, the Breast Cancer Chemotherapy Questionnaire (BCQ) proved valid as measure of subjective health status and was able to distinguish long vs. short arms. Well-validated measures of physical and emotional function developed by the Rand Corporation were unable to distinguish between the two groups. The Eastern Co-operative Oncology Group Criteria (ECOG) distinguished the two groups, but failed criteria of clinical sensibility as a measure of subjective health status. In a study of patients with Crohn's disease and ulcerative colitis, the Inflammatory Bowel Disease Questionnaire (IBDQ) showed small intrasubject variability over time. Global ratings of change showed moderate to high correlations with changes in IBDQ score. Each of these findings support, in different ways, the reproducibility, validity, and responsiveness of the questionnaire. While the same data can at times bear on both validity and responsiveness, when assessing evaluative instruments it is useful to make a conceptual distinction between the two. (19 references) AA

Address for reprint requests: McMaster University Health Centre, Room 3H7, 1200 Main Street West, Hamilton, Ontario, Canada

REFERENCE NUMBER 19

Au: Harrington, Joseph E. Jr.

Ti: **If *Homo Economics* Could Choose His Own Utility Function, Would He Want One With a Conscience? Comment**

So: *American Economic Review* 79(3):588-593, 1989

This article comments on an earlier article in the *American Economic Review* in which it was found that honest agents can always successfully invade a population of dishonest agents and thereby introduce cooperative behavior into the environment. The central conclusions are dependent upon the existence of

a signal that perfectly conveys that an agent is honest. In the absence of such a signal, we show that a small mutation of honest agents is never successful in invading a population of dishonest agents. In contrast, a mutation of dishonest agents is always successful in invading a population of honest agents and, in some cases, invasion results in the elimination of all cooperative behavior. (3 references) AA

Address for reprint requests: Department of Economics, The Johns Hopkins University, Baltimore, Maryland 21218

REFERENCE NUMBER 20

Au: Hirschman, Albert O.

Ti: **The Quality of Life: Having Opinions—One of the Elements of Well-Being?**

So: *American Economic Review* 79(2):75–79, 1989

The author examines “having opinions,” an ingredient of quality of life. A quick glance suggests that opinions can be treated like consumer goods: The more the better, as well as, in this case, the stronger the better. If carried beyond some point, however, the process of forming and acquiring opinions can have dangerous side effects. The author argues that the traditional bias in favor of having strong opinions ought to be modified since such opinions may be dangerous to the health of our democracy. (9 references) AA

Address for reprint requests: School of Social Science, Institute for Advanced Study, Princeton, New Jersey 08540

REFERENCE NUMBER 21

Au: Homel, Ross; Burns, Ailsa

Ti: **Environmental Quality and the Well-Being of Children**

So: *Social Indicators Research* 21(2):133–158, 1989

There are many reasons for believing that the environment exerts an influence (directly or indirectly) on the Well-Being of children and families. However, while clear evidence is available that low socioeconomic status is associated with lower than average levels of Well-Being, especially among adults, the evidence linking the social and emotional adjustment of children with the quality of the environment is patchy and equivocal. In this paper we focus on three levels of the family environment: The street, the home, and the neighborhood. Neighborhood quality was measured by the Vinson-Homel social problems index; street-type, as residential or commercial/retail; and housing quality in terms of upkeep, floor occupied, availability of playspace, and occupancy type. The research hypothesis was that after allowing for community selection processes, children living in lower quality environments would be less satisfied with various areas of their lives, would experience more negative emotions, and would have more restricted and less positive friendship patterns. The sample comprised 321 families which included a 9–11-year-old child, drawn from 18 neighborhoods of Sydney. Neighborhood social problem score and street-type, and some aspects of housing, predicted emotional and social adjustment. Before and after controls for family composition, social class, and culture, children living in commercial streets, particularly in inner-city areas, stood out from all others in their feelings of loneliness, dislike of other children, and feelings of rejection, worry, fear, anger, and unhappiness. Children living in high social problem areas showed a pattern of social constriction rather than maladjustment. These results suggest not simply the influence of social class but genuine community socialization effects. Possible sources of, and mechanisms for, these effects are suggested. (34 references) AA

Address for reprint requests: School of Behavioral Sciences, Macquarie University, North Ryde, N.S.W. 2113, Australia.

REFERENCE NUMBER 22

Au: Hume, Anne L.

Ti: **Applying Quality of Life Data in Practice: Considerations for Antihypertensive Therapy**

So: *Journal of Family Practice* 28(4):403-411, 1989

Quality-of-life issues have become increasingly important in tailoring antihypertensive therapy to individual patients. The application of quality-of-life data to the practice setting is frequently difficult, however. The effective use of this information requires an understanding of its definition and measurement, as well as of study methods. Quality-of-life findings may be specific to particular disease states, patient populations, and pharmacologic agents. The addition of hydrochlorothiazide concurrent with methyldopa, propranolol, or captopril therapy has been reported to reduce patients' overall sense of Well-Being. Beta-adrenergic blockers may exert either positive or negative effects on quality of life. Angiotensin-converting enzyme (ACE) inhibitors may have positive effects on quality of life; however, the cost of therapy is an important consideration. Information on calcium antagonists is limited. The findings of the Treatment of Mild Hypertension Study (TOMHS) may eventually provide comparative quality-of-life data on the four first-line antihypertensive therapies. (22 references) AA

Address for reprint requests: College of Pharmacy, Fogarty Hall, The University of Rhode Island, Kingston, Rhode Island 02881

REFERENCE NUMBER 23

Au: Hunt, Linda M.; Jordan, Brigitte; Irwin, Susan

Ti: **Views of What's Wrong: Diagnosis and Patients' Concepts of Illness**

So: *Social Science and Medicine* 28(9):945-956, 1989

A group of women were interviewed about their construction of their illness experiences before they saw a physician and subsequently over a period of several months following consultation. It was found that the physician's input was one of many components of their postconsultation understanding of their illnesses. The women built up their understandings in an interactive process, drawing significantly on their prior histories, ongoing experiences, and social worlds. They continually tried out, adjusted, and reworked the construction of their illness to adapt them to the exigencies of everyday life. We conclude that illness explanations are dynamic entities whose adequacy is determined by their usefulness within the extramedical social environment. (26 references) AA

Address for reprint requests: Department of Anthropology, Harvard University, Cambridge, Massachusetts 02138

REFERENCE NUMBER 24

Au: Keil, J.E.; Gazes, P.C.; Sutherland, S.E.; Rust, P.F.; Branch, L.G.; et al.

Ti: **Predictors of Physical Disability in Elderly Blacks and Whites of the Charleston Heart Study**

So: *Journal Clinical of Epidemiology* 42(6):521-529, 1989

During the 1984-85 recall of the Charleston Heart Study Cohort, physical function data were obtained for 247 white males, 376 white females, 123 black males, 247 black females, and 71 high socioeconomic status (SES) black males over 60 years of age. Black females had the highest prevalence of physical disability (55.8 percent), followed by white females (43.2 percent), black males (39.0 percent), white males (25.8 percent), and high SES black males (22.3 percent). Physical disability was 1.5-2.5 times as prevalent among individuals with a history of cardiovascular disease (CVD) as among those without such a history. Among individuals without a current history of CVD, univariate analyses showed the following as significant predictors of physical disability: Elevated systolic blood pressure in white females, black males, and black females; elevated cholesterol in black females; and low educational level in white females. Regression analyses indicated that obesity in 1960 accounted for 10.9 percent and 2.9 percent, respectively, of the variability in physical disability scores in 1985 for black females and white females. (14 references) AA

Address for reprint requests: Department of Biometry, Medical University of South Carolina, 171 Ashley Avenue, Charleston, South Carolina 29425

REFERENCE NUMBER 25

Au: Kinney, Jennifer M.; Stephens, Mary Ann Parris

Ti: **Caregiving Hassles Scale: Assessing the Daily Hassles of Caring for a Family Member With Dementia**

So: *Gerontologist* 29(3):328-332, 1989

Examined was a scale designed to assess the daily hassles of caring for a family member with Alzheimer's Disease (AD). Primary caregivers to AD patients (N = 60) completed the Caregiving Hassles Scale on two occasions and reported on their Well-Being. The 42-item scale provides a reliable and psychometrically sound instrument for assessing hassles associated with assistance in basic activities of daily living (ADL), assistance in instrumental ADL, care-recipients' cognitive status, care-recipients' behavior, and caregivers' social network. (12 references) AA

Address for reprint requests: Gerontology Program, College of Health and Human Services, Bowling Green State University, Bowling Green, Ohio 43403-0280

REFERENCE NUMBER 26

Au: Koyano, Wataru; Shibata, Hiroshi; Nakazato, Katsuharu; Haga, Hiroshi; Suyama, Yasuo; et al.

Ti: **Mortality in Relation to Instrumental Activities of Daily Living: One-Year Follow-up in a Japanese Urban Community**

So: *Journal of Gerontology* 44(3):S107-S109, 1989

One-year mortality among 7,573 elderly residents living in an urban Japanese community was observed in relation to disability in instrumental activities of daily living (IADL). Disability in IADL was assessed for seven items of activity, including using public transportation, using the telephone, and shopping. When the effects of age were controlled, the mortality rate was significantly higher in disabled than in nondisabled persons for all seven items for both males and females. (17 references) AA

Address for reprint requests: Department of Sociology, St. Andrew's University, 237-1 Nishino, Sakai City, Osaka 588, Japan

REFERENCE NUMBER 27

Au: Larsson, Ullabeth Satterlund; Svardsudd, Kurt; Wedel, Hans; Saljo, Roger

Ti: **Patient Involvement in Decision-Making in Surgical and Orthopaedic Practice: The Project Perioperative Risk**

So: *Social Science and Medicine* 28(8):829-835, 1989

As part of the Project Perioperative Risk (PROPER), which is a clinical and epidemiological study of surgical complications, patient involvement in the decision to operate was evaluated by means of a questionnaire. The sample of 666 patients, on the waiting list for an operation, received a questionnaire on a broad range of issues concerning their involvement in the decisionmaking process 1 week before the operation. The results show that 41 percent regarded the decision to have an operation as a joint patient-doctor decision, in 29 percent of the cases the doctor advocated an operation, and in 8 percent the patient asked to be operated. A clear majority, 73 percent, felt involved in the decisionmaking as much as they wished. Two groups—women and immigrants from non-European countries—were least satisfied with their involvement, and they also found the decision more difficult to make. In the discussion, it is argued that the comparatively high degree of patient satisfaction with involvement in the decisionmaking process cannot be taken as evidence of a high level of influence in an absolute sense. In a normative perspective—and considering the fact that the increased responsibility of the health sector is aimed at involving patients in decisionmaking in health matters—patient satisfaction can just as well be understood as resulting from low expectations with respect to one's influence. The results also indicate that a patient's

information needs when facing surgery relate to three issues: Possible complications, precise nature of the operation as such, and nature and consequences of anaesthetic procedures. (39 references) AA

Address for reprint requests: Department of Medicine, Section of Preventive Medicine, Ostra Hospital, S-416 85 Gothenburg, Sweden

REFERENCE NUMBER 28

Au: Levy, Haim

Ti: **Two-Moment Decision Models and Expected Utility Maximization: Comment**

So: *American Economic Review* 79(3):597-600, 1989

The two most common approaches to analyzing behavior under uncertainty are the expected utility (EU) model and the mean-standard deviation (MS) model. In this note the author proves that under a certain restriction on the support of the distribution, random variables that are mean-standard deviation efficient are also efficient in the expected utility model, that is, MS and EU yield identical efficient sets. The relationship of MS- and EU-efficient sets for all unrestricted utility (U) and alternatively for all risk-averse U are analyzed separately. Only pairwise comparisons of risky options are considered. (7 references) AA

Address for reprint requests: School of Business, Hebrew University, Mt. Scopus, Jerusalem, Israel 91905

REFERENCE NUMBER 29

Au: Liang, Jersey; Tran, Thanh Van; Krause, Neal; Markides, Kyriakos S.

Ti: **Generational Differences in the Structure of the CES-D Scale in Mexican Americans**

So: *Journal of Gerontology* 44(3):S110-S120, 1989

This study examines differences in the structure of the Center for Epidemiologic Studies Depression (CES-D) scale across three generations of Mexican-Americans. The covariance structure of the items was viewed as a function of several parameter matrices. Factorial invariance was evaluated by testing a series of hypotheses involving equivalence constraints on one or more parameter matrices. The findings revealed that the proposed 12-item model fits the data within each of the three generations adequately. Although no generational differences in factor loading were revealed, structural variations of the CES-D in measurement error variances were found. Measurement error variances associated with certain items in the older generation are significantly greater than those in the middle-aged and young generations. In addition, socioeconomic characteristics, acculturation, and health status fail to explain the observed differences in the structure of the CES-D among the three generations. (47 references) AA

Address for reprint requests: Institute of Gerontology, The University of Michigan, 300 Ingalls, Ann Arbor, Michigan 48109-2007

REFERENCE NUMBER 30

Au: Lin, Nan; Ensel, Walter M.

Ti: **Life Stress and Health: Stressors and Resources**

So: *American Sociological Review* 54:382-399, 1989

In the life stress process, social, psychological, and physiological environments simultaneously impinge on Well-Being. In this paper we focus on physical health as it is affected by two environmental elements: Stress(or)es and resources. Data from a three-wave panel survey of a representative upstate New York community are examined by lagged causal relationships among these variables. The results show that (1) prior physiological conditions contribute directly to current physical symptoms, (2) stress and resource components of the psychological environment directly affect current physical symptoms, (3) social resources buffer both social stressors and psychological stress, whereas psychological resources buffer only

psychological stress, and (4) psychological stress mediates the effects of prior social stressors and psychological resources. Clearly, stress is a complex process in which the three interacting environments affect Well-Being. Importantly, social resources play a buffering role relative to social and psychological stresses for physical Well-Being. (57 references) AA

Address for reprint requests: State University of New York, Albany, New York

REFERENCE NUMBER 31

Au: Mastekaasa, Arne; Kaasa, Stein

Ti: **Measurement Error and Research Design: A Note on the Utility of Panel Data in Quality of Life Research**

So: *Social Indicators Research* 21(3):315-335, 1989

The authors discuss various strategies for dealing with measurement error in subjective indicators research, with the main purpose being to suggest an alternative, or rather a supplement, to the currently most popular approaches. Ideas from the econometrics literature are introduced to suggest other types of research designs that can be used to deal with measurement error. These ideas are applied to subjective Well-Being data, with special focus on the question of systematic measurement error. (22 references) CH-P

Address for reprint requests: Institute for Social Research, Munthesgata 31, N-0260 Oslo, Norway

REFERENCE NUMBER 32

Au: McClelland, David C.

Ti: **Motivational Factors in Health and Disease**

So: *American Psychologist* 44(4):675-683, 1989

Evidence is reviewed that measures of motive strength, as measured through content analysis of associative thought, are related to physiological systems, the functioning of which affect health outcomes. Studies show that affiliative and power motive syndromes assessed in associative thought are associated with health and illness. A relaxed or easygoing affiliative motive syndrome characterizes insulin-dependent Type I diabetics and can, if aroused, lead to poorer blood sugar control in such diabetics. A stressed power motive syndrome is associated with sympathetic activation, release of stress hormones, depressed immune functions, and greater susceptibility to infectious diseases. Affiliative trust and a greater sense of agency as measured in associative thought content are associated with better health. An intervention study and a longitudinal study have demonstrated that differences in the levels of these motivational variables are not simply the result of illness but lead to alterations in subsequent health status. (34 references) AA

Address for reprint requests: Center for Applied Social Science, Boston University, 232 Bay State Road, Boston, Massachusetts 02215

REFERENCE NUMBER 33

Au: Merbitz, Charles; Morris, Jeri; Grip, Jeffrey C.

Ti: **Ordinal Scales and Foundations of Misinference**

So: *Archives of Physical Medicine and Rehabilitation* 70(4):308-312, 1989

Fundamental deficiencies in the information provided by an ordinal scale constrain the logical inferences that can be drawn; inferences about progress in treatment are particularly vulnerable. Ignoring or denying the limitation of scale information will have serious practical and economic consequences. Currently, there is a high demand for functional assessment scales within the rehabilitation community. It is hoped that such scales will satisfy the very real need for measures of function that reflect the impact of treatment on

patient progress. Unfortunately, some commonly used evaluation instruments are not well suited to this task. The underlying rationale for clinical decisionmaking based on these scales is examined. (12 references) AA

Address for reprint requests: Learning Research Unit, Rehabilitation Institute of Chicago, 448 East Ontario Street, Chicago, Illinois 60611

REFERENCE NUMBER 34

Au: Meyers, Allan R.; Branch, Laurence G.; Cupples, L. Adrienne; Lederman, Ruth I.; Felton, Marie
Ti: **Predictors of Medical Care Utilization by Independently Living Adults With Spinal Cord Injuries**
So: *Archives of Physical Medicine and Rehabilitation* 70(6):471-476, 1989

A prospective study of 87 independently living adults with spinal cord injury (SCI) as a major disabling condition showed the following average annual health care utilization rates: 1.3 hospital admissions, 16.8 days hospitalized, 1.7 emergency room (ER) visits, and 22.4 outpatient contacts (in person or by telephone). Those hospitalized (n = 66) experienced a mean of 22.2 days hospitalized per person per year. Mean length of stay (LOS) was 11.1 days per admission. Stepwise regression analysis indicated no statistically significant predictors of hospital admission. There were three independent predictors of days hospitalized (greater age, fewer years of education, and more days hospitalized during the previous year), three predictors of days hospitalized for those hospitalized only (greater age, fewer years of education, and longer hospital LOS during the previous year), one predictor of LOS (self-assessment of health), three predictors of emergency room (ER) visits (more unmet instrumental activities of daily living needs, lack of organizational memberships, and more ER visits during the previous year), and five predictors of outpatient contacts (greater age, less satisfaction with health care providers' expression of concern for their health, lower frequency of leaving apartments, lower levels of life satisfaction, and nonparticipation in a managed medical care demonstration project). Many predictors of health services utilization are immutable. However, changes that facilitate social interaction and changes in the organization of health services may reduce certain types of medical care utilization by people with SCI. (15 references) AA

Address for reprint requests: Boston University School of Medicine, 80 East Concord Street, A-302, Boston, Massachusetts 02118-2394

REFERENCE NUMBER 35

Au: Millard, Richard W.
Ti: **The Functional Assessment Screening Questionnaire: Application for Evaluating Pain-Related Disability**
So: *Archives of Physical Medicine and Rehabilitation* 70(4):303-307, 1989

The Functional Assessment Screening Questionnaire (FASQ) is a 15-item checklist which was developed for primary care populations and may serve as a questionnaire method for evaluating disability which is associated with chronic pain. As part of an initial multidisciplinary evaluation of chronic pain, 158 patients completed the FASQ. Reliability was reaffirmed through split-half and alternate-form methods. Responses were examined to explore relationships to aspects of disability. Although job functions were not directly assessed, the scores of employed vs. unemployed respondents differed significantly. Findings were related to Minnesota Multiphasic Personality Inventory scale scores but appeared to reflect a separate phenomenon. Scale 1 (Hs) was the most useful scale for predicting level of reported impairment. Nonparametric methods showed levels of functioning varying significantly by site of pain complaint. Patients with back pain reported the most difficulty; those with head pain and genital pain reported the least difficulty. An internal structure appropriate to chronic pain populations was discerned, with two general factors measuring either physical-motoric or cognitive-social aspects of disability. Aside from

constraints associated with the use of self-report methods, the FASQ may be helpful as part of efforts to portray pain-related disability. (20 references) AA

Address for reprint requests: Pain Management Center, The Buffalo General Hospital, 100 High Street, Buffalo, New York 14203

REFERENCE NUMBER 36

Au: Moller, V.; Schlemmer, L.

Ti: **South African Quality of Life: A Research Note**

So: *Social Indicators Research* 21(3):279-291, 1989

A nationwide survey (n = 5,587) was conducted in 1982-83 with a view to developing a reliable crosscultural index of quality of life of South Africa. Findings confirmed the known underprivileged position of black persons relative to other groups in terms of some 60 objective and subjective indicators. Contrary to expectations the results of factor and regression analyses indicated that the linear additive model of quality of life as a whole cannot account for its full complexity. The possibility is considered that more broadly symbolic factors related to relative deprivation may make an independent contribution to perceived overall Well-Being. In conclusion, a single crosscultural, albeit multi-item, measure of South African quality of life is recommended. (10 references) AA

Address for reprint requests: Centre for Social and Development Studies, University of Natal, King George V Avenue, Durban 4001, Republic of South Africa

REFERENCE NUMBER 37

Au: Mossey, Jana M.; Mutran, Elizabeth; Knott, Kathryn; Craik, Rebecca

Ti: **Determinants of Recovery 12 Months After Hip Fracture: The Importance of Psychosocial Factors**

So: *American Journal of Public Health* 79(3):279-286, 1989

The independent contributions to recovery from hip fracture of psychosocial factors including depression, personality, social connectedness, and self-rated health were studied in 219 women age 59 years and older (mean age, 78.5 years) who were community dwelling prior to fracture. Initial assessments were conducted shortly after surgery and followup assessment 2.6 and 12 months later. By 12 months, 15 patients had died and 15 had entered a nursing home. Substantial declines in physical functioning though not psychosocial status were observed. Only 21 percent (compared with 81 percent prefracture) reported walking independently; fewer than 30 percent had regained reported prefracture levels of physical function. The proportion with elevated depression scores at 12 months was 20 percent, down from 51 percent following surgery; 64 percent rated their health excellent or good at 12 months, up from 43 percent after surgery. Poor cognitive status and postsurgical self-related health were predictive of mortality. Among survivors, age, prefracture physical functioning, and cognitive status were associated with recovery in physical function but not psychosocial status. High postsurgery depression scores, but not the other psychosocial factors, were associated with poorer recovery in both functional and psychosocial status. These findings demonstrate the importance of depressive symptoms as one determinant of recovery from hip fracture and support the need to attend to the affective status of hip fracture patients following surgery. (34 references) AA

Address for reprint requests: Medical College of Pennsylvania, EPPI Division, 3200 Henry Avenue, Philadelphia, Pennsylvania 19129

REFERENCE NUMBER 38

Au: Motenko, Aluma Kopito

Ti: **The Frustrations, Gratifications, and Well-Being of Dementia Caregivers**

So: *Gerontologist* 29(2):166-172, 1989

Face-to-face interviews with 50 older women caring at home for a husband with dementia revealed that gratification was associated with greater well-being, and frustration, with more distress. Wives who perceived continuity in marital closeness since the illness had greater gratification than those who perceived change. Frustrations, in disrupting life plans, are apparently greatest at the onset of symptoms and as routines are developed, diminish despite the need to provide more care. Still, the meanings of caregiving are more important to caregiver Well-Being than the amount of care provided. (26 references)

AA

Address for reprint requests: Salem State College, School of Social Work, 352 Lafayette St., Salem, Massachusetts 01970

REFERENCE NUMBER 39

Au: Newhouse, Joseph P.; Manning, Willard G.; Keeler, Emmett B.; Sloss, Elizabeth M.

Ti: **Adjusting Capitation Rates Using Objective Health Measures and Prior Utilization**

So: *Health Care Financing Review* 10(3):41-54, 1989

Several analysts have proposed adding adjusters based on health status and prior utilization to the adjusted average per capita cost formula. The authors estimate how well such adjusters predict annual medical expenditures among nonelderly adults. Both measures substantially improve on the variables currently used. If only health measures are added, 20-30 percent of the predictable variance is explained; if only prior use is added, more than 40 percent is explained; if both are added, about 60 percent is explained. The results support including some measure of use in the formula until better health measures are developed. (28 references) AA

Address for reprint requests: Division of Health Policy Research and Education, 25 Shattuck St. Parcel B, First Floor, Boston, Massachusetts 02115

REFERENCE NUMBER 40

Au: OConnell, Paul G.; Gnatz, Steven

Ti: **Hemiplegia and Amputation: Rehabilitation in the Dual Disability**

So: *Archives of Physical Medicine and Rehabilitation* 70(6):451-454, 1989

About 10 percent of all elderly dysvascular amputees have had cerebrovascular accidents at some time. This is an often overlooked but important fact which significantly impacts the outcomes of their rehabilitation, especially where prosthetic ambulation is attempted. This study reviews the rehabilitation outcomes of 46 patients with the dual disability of hemiplegia and amputation. The mean age of the patients was 63 years (range 49 to 84). Forty-one (89 percent) could participate in a trial of physical therapy, and 25 (54 percent) in a comprehensive rehabilitation program. Seventeen (37 percent) were fitted with a prosthesis, and 12 (26 percent) became independent ambulators. Eighteen (39 percent) achieved independence in their activities of daily living (ADL) and transfers. Patients were reviewed to establish those features predictive of a good outcome. The following factors were associated with regaining independent ambulation: the presence of a mild hemiparesis with residual hand function, a below-knee amputation, and a history of ambulation before the second disability. The ADL independence was associated with a mild hemiparesis, and age less than 60 years. Of those patients who did achieve independent ambulation, 73 percent were still ambulating a mean of 16.5 months later. These findings

should be considered when planning rehabilitation goals for patients with the dual disability of hemiplegia and amputation. (19 references) AA

Address for reprint requests: Department of Rehabilitation Medicine, National Institutes of Health, Building 10, Room 6S235, Bethesda, Maryland 20892

REFERENCE NUMBER 41

Au: O'Donnell, Rita Mahard

Ti: **Functional Disability Among the Puerto Rican Elderly**

So: *Journal of Aging and Health* 1(2):244-264

This article reports data on the functional status of elderly Puerto Ricans derived from a recent large-scale household survey of this group in the New York metropolitan area. A comparison of our findings on Puerto Ricans to national data on black and white elderly reveals that Puerto Ricans are significantly more disabled than either the black or white elderly. When the demographic factors and the English language disadvantage that distinguish Puerto Ricans from both black and white populations are taken into account, our estimate of the effect of race-ethnicity on disability is reduced, but a considerable effect remains. The data suggest that older Puerto Ricans are at high risk for dependency, and that within this population, persons whose lack of English severely limits their capacity to interact with the environment are at particular risk. (28 references) AA

Address for reprint requests: Fordham University, New York, New York

REFERENCE NUMBER 42

Au: O'Hara, Michael W.; Ghoneim, Mohamed M.; Hinrichs, James V.; Mehta, Mahesh P.; Wright, Ellen J.

Ti: **Psychological Consequences of Surgery**

So: *Psychosomatic Medicine* 51(3):356-370, 1989

The purpose of the present study was to assess changes in psychological distress and memory complaint following a wide variety of surgeries. In addition, variables reflecting type of surgery, demographic characteristics, history of mental illness, and health factors were evaluated as predictors of postoperative psychological distress and memory complaint. Using the Brief Symptom Inventory (BSI), it was found that 10.9 percent of patients had high levels of psychological distress the day before surgery compared with 13.9 percent percent of patients 3 months after surgery. Complaints of memory disturbance also increased significantly. Only the anxiety subscale of the BSI showed a significant decrease at 3 months postsurgery. Hierarchical multiple regression revealed that younger age, lower social status, being male, having a history of mental illness, higher presurgery BSI, and poorer postsurgery health were significant predictors of postsurgery psychological distress. The results of the study suggest that, although patients become less anxious after surgery, other forms of emotional distress increase, perhaps due to factors such as slower than anticipated recovery. Results also suggest that medical factors may play an indirect rather than a direct role in psychological consequences of surgery. (38 references) AA

Address for reprint requests: Department of Psychology, University of Iowa, Iowa City, Iowa 52242

REFERENCE NUMBER 43

Au: Pace, Wilson D.

Ti: **Geriatric Assessment in the Office Setting**

So: *Geriatrics* 44(6):29-35, 1989

Attention to functional limitations must be incorporated into the routine care of the elderly. Several brief, validated functional assessment instruments are now available for office use. Routine screening of the

elderly population typically uncovers unknown concerns in one-third to one-half of patients, even if those patients are well known to their physician. Functional assessment instruments have been developed with specific site and populations in mind. Therefore, physicians should evaluate which instrument best matches the population to be tested. Functional measures should be viewed as an adjunct to improving care, not as a stand-alone diagnostic test. (29 references) AA

Address for reprint requests: University of Colorado Health Sciences Center, Campus Box B155, 1180 Clermont Street, Denver, Colorado 80220

REFERENCE NUMBER 44

Au: Rogers, Andrei; Rogers, Richard G.; Branch, Laurence G.

Ti: **A Multistate Analysis of Active Life Expectancy**

So: *Public Health Reports* 104(3):222-225, 1989

Using longitudinal data sets and new methodological techniques, researchers have begun to assess active life expectancies, estimating not only how long a subpopulation can expect to live beyond each age, but what fractions of the expected remaining lifetime will be lived as independent, dependent, or institution-alized. New ideas are addressed, applying recently developed multistate life table methods to Waves One and Two of the Massachusetts Health Care Panel Study. Expectations of active life are presented for those 65 years and older who initially are in one of two functional states of Well-Being. Included are expectations of life, for those, for example, who were independent and remained so, or those who were dependent and became independent. Preliminary analysis shows that a significant number of the dependent elderly regain their independence, a situation that needs to be addressed in health care planning. (7 references) AA-M

Address for reprint requests: Institute of Behavioral Science, Campus Box 484, University of Colorado, Boulder, Colorado 80309

REFERENCE NUMBER 45

Au: Rubenstein, Lisa V.; Calkins, David R.; Greenfield, Sheldon; Jette, Alan M.; Meenan, Robert F.; et al.

Ti: **Health Status Assessment for Elderly Patients: Report of the Society of General Internal Medicine Task Force on Health Assessment**

So: *Journal of the American Geriatrics Society* 37(6):562-569, 1988

This report suggests practical, validated measures for assessing physical, psychological, and social functioning in daily life. These measures, often called instruments, are particularly relevant and useful among elderly individuals, who frequently have multiple disabilities. Functional status instruments can be used in office or hospital practice to achieve clinical goals such as detecting disability, measuring patient progress over time, planning for long-term care, and assessing disease severity. (53 references) AA

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

REFERENCE NUMBER 46

Au: Satariano, William A.; Ragheb, Nawal E.; Buck, Karen A.; Swanson, G. Marie; Branch, Laurence G.

Ti: **Aging and Breast Cancer: A Case-Control Comparison of Instrumental Functioning**

So: *Journal of Aging and Health* 1(2):209-233, 1989

The level of instrumental functioning of breast cancer cases aged 55 to 84 years is compared to that of women of the same age without the disease. A total of 571 cases were selected through the Metropolitan Detroit Cancer Surveillance System and interviewed 3 (n = 463) and 12 (n = 422) months after diagnosis

about their needs in transportation, housekeeping, meal preparation, and grocery shopping. A total of 647 controls aged 55 to 84 years were selected through random-digit dialing and interviewed twice over the same period (n = 539 and 478). At 3 months, cases aged 55 to 74 years report greater difficulty and less independence than controls in completing instrumental tasks. Little difference is shown between cases and controls aged 75 to 84 years. Nine months later, functional status is similar for cases and controls aged 55 to 64 years. In contrast, cases aged 65 to 74 years continue to be less independent than controls of the same age. (28 references) AA

Address for reprint requests: School of Public Health, University of California, Berkeley, California 94720

REFERENCE NUMBER 47

Au: Stark, Oded

Ti: **Altruism and the Quality of Life**

So: *American Economic Review* 79(2):86-90, 1989

The author argues that "some" altruism is insufficient to entail a Pareto improvement. In a situation where altruism is absent altogether, however, the prevalence of just some altruism could result in Pareto inferior outcomes. Thus, if the formation of just some altruism may not only fail to do any good but could actually make things worse whereas the formation of sufficiently high levels of altruism is almost always beneficial, a troubling discontinuity arises: To the extent that the formation of altruism has to be gradual, groups yearning to build up their social stock of altruism may have to endure Paretial gains. Perhaps one reason why a great many societies consist largely of self-interested economic men and women rather than of altruistic economic men and women has to do with this monotonicity. (2 references) CH-P

Address for reprint requests: Harvard University, Cambridge, Massachusetts 02138

REFERENCE NUMBER 48

Au: Stewart, Miriam J.

Ti: **Social Support: Diverse Theoretical Perspectives**

So: *Social Science and Medicine* 28(12):1275-1282, 1989

The useful predictions and interpretations about social support which can be derived from attribution, coping, equity, loneliness, and social comparison theories have typically not been recognized. Attribution theory can enable explanation of motives of donors, the phenomena of help-seeking and helping, and negative effects of support efforts. Coping theory demonstrates how social support and coping interface in the stress process, adds a cognitive dimension to support, and considers costs of support. Equity theory explains reactions to support from donor and recipient viewpoints and the reciprocal nature of social support. Loneliness theory attests to the significance of social relationships and emphasizes the affective dimension of support. Social comparison theory is helpful in interpreting positive and debilitating effects of support when the donor is a peer. Further, these five theories enhance theoretical interpretation of social support through their distinctive explanations of the concepts of "appraisal" and "helping." Relevance to health professional assessment and practice can be delineated. (50 references) AA

Address for reprint requests: Faculty of Health Professions, Dalhousie University School of Nursing, Halifax, Nova Scotia B3H 3J5, Canada

REFERENCE NUMBER 49

Au: Stones, M.J.; Kozma, Albert

Ti: **Multidimensional Assessment of the Elderly via a Microcomputer: The SENOTS Program and Battery**

So: *Psychology and Aging* 4(1):113-118, 1989

We compared the psychometric adequacy of a multidimensional self-report battery for use with cognitively able, elderly adults under conditions of microcomputer and interviewer administration. The SENOTS battery contains scales of Happiness/Depression, Financial Hardship, Physical Symptoms, Activity Limitations, and Activity Propensity. The SENOTS microcomputer program contains sequential phases intended to (a) select out respondents incapable of interacting adequately with the microcomputer, (b) train respondents to make appropriate keyboard responses, (c) administer the program, and (d) store and process the responses. The SENOTS battery was administered to 80 community residents and 80 institution residents by either a microcomputer or an interviewer. Results indicated a comparable psychometric adequacy to the SENOTS battery under both administration conditions. Internal consistencies were all at acceptable levels, and the scales differentiated the community residents from the institution residents. (11 references) AA

Address for reprint requests: Gerontology Centre and Department of Psychology, Memorial University of Newfoundland, St. John's, Newfoundland, A1B 3X9 Canada

REFERENCE NUMBER 50

Au: Tsevat, Joel; Durand-Zaleski, Isabelle; Pauker, Stephen G.

Ti: **Cost-Effectiveness of Antibiotic Prophylaxis for Dental Procedures in Patients With Artificial Joints**

So: *American Journal of Public Health* 79(6):739-743, 1989

The authors performed a cost-effectiveness analysis to evaluate whether patients with artificial joints should take penicillin, erythromycin, or no antibiotics before dental procedures. We modeled the risk of anaphylaxis from penicillin, the risks and consequences of an artificial joint infection, and the actual variable costs of hospitalization and antibiotics. Penicillin prophylaxis is slightly less expensive than erythromycin prophylaxis but is both more expensive and less effective than no prophylaxis. Erythromycin prophylaxis, the most effective, is the most expensive strategy. The marginal cost-effectiveness of erythromycin prophylaxis compared with no prophylaxis is 12,900 per quality-adjusted year of life saved. Sensitivity analysis demonstrates that the risk of developing a joint infection is the key parameter in the analysis. Based on the estimated risk of developing a joint infection, the cost-effectiveness of antibiotic prophylaxis with erythromycin compares favorably with other medical interventions. Thus, until a definitive study to quantify the risk is conducted, patients with artificial joints should take prophylactic erythromycin when they undergo dental procedures. (8 references) AA

Address for reprint requests: Division of Clinical Decision Making, Box 302, New England Medical Center, 750 Washington Street, Boston, Massachusetts 02111

REFERENCE NUMBER 51

Au: Tugwell, P.; Bombardier, C.; Bensen, W.; Grace, E.; Bennett, K.; et al.

Ti: **Current Quality-of-Life Research Challenges in Arthritis Relevant to the Issue of Clinical Significance**

So: Unpublished, Hamilton, Ontario, Canada: McMaster University

This paper focuses on the question of clinical significance of evaluative indices of quality of life. The role of quality-of-life assessments in rheumatology studies is reviewed, the limitations that affect their clinical significance are discussed, and some strategies for addressing these limitations are described. (20 references) AA

Address for reprint requests: Department of Clinical Epidemiology and Biostatistics, McMaster University, 1200 Main Street West, Hamilton, Ontario, Canada L8N 3Z5

REFERENCE NUMBER 52

Au: Vertrees, James C.; Manton, Kenneth G.; Adler, Gerald S.

Ti: **Cost Effectiveness of Home and Community-Based Care**

So: *Health Care Financing Review* 10(4):65-78, 1989

Medicaid section 2176 waivers allow States to provide home and community-based care to Medicaid eligibles who, but for these services, would enter Medicaid-funded nursing homes. One of the conditions required by the U.S. Congress for granting these waivers is that this substitution results in no additional Medicaid spending (budget neutrality). The results of case studies of two of these waiver programs, one in California and one in Georgia, are presented in this article. The case studies contain a description of the operation of these programs in some detail. Next, the data and techniques needed to assess the ability of these programs to achieve budget neutrality are presented, and the performance of these programs along this dimension is evaluated. (9 references) AA

Address for reprint requests: Center for Demographic Studies, 2117 Campus Drive, Durham, North Carolina 27706

REFERENCE NUMBER 53

Au: Weinstein, Milton C.; Berwick, Donald M.; Goldman, Paula A.; Murphy, Jane M.; Barsky, Arthur J.

Ti: **A Comparison of Three Psychiatric Screening Tests Using Receiver Operating Characteristic (ROC) Analysis**

So: *Medical Care* 27(6):593-606, 1989

Self-administered screening questionnaires are available to assist primary care physicians in detecting undiagnosed depression and anxiety disorders. This study used receiver operating characteristic (ROC) analysis to evaluate three such tests: The General Health Questionnaire (GHQ), the Mental Health Inventory (MHI), and the Somatic Symptom Inventory (SSI). Stratified by the results of a preliminary GHQ, 364 health maintenance organization (HMO) members were given these tests as well as a Diagnostic Interview Schedule (DIS), the latter used as a "truth" standard for current psychiatric diagnosis. The MHI performed significantly better than the GHQ in detecting mental disorders generally and anxiety disorders in particular, and somewhat better in detecting affective disorders. The SSI performed best in detecting anxiety disorders and was significantly better than the GHQ. When subjects who had participated in a previous study involving repeated GHQ administration were excluded, sensitivity of all tests improved, especially the GHQ. The authors conclude that the MHI can be a useful

tool for screening primary care patients, and that the SSI has additional predictive value with respect to anxiety disorders. (58 references) AA

Address for reprint requests: Department of Health Policy and Management, Harvard School of Public Health, 677 Huntington Avenue, Boston, Massachusetts 02115

REFERENCE NUMBER 54

Au: Williams, Simon Johnson

Ti: **Chronic Respiratory Illness and Disability: A Critical Review of the Psychosocial Literature**

So: *Social Science and Medicine* 28(8):791-803, 1989

The paper attempts to offer a critical review of the current psychosocial literature on chronic obstructive airways disease (COAD: Emphysema, chronic obstructive bronchitis, and chronic asthma) from a (medical) sociological perspective. Following a brief exposition of the clinical nature of COAD and its epidemiology, the paper reviews some of the main psychosocial literature in the field. It then focuses on some of the problems concerning issues of methodology and measurement within the existing research, particularly the inadequacy of many of the "quality-of-life" instruments and disability measures used; the lack of research that combines both quantitative and qualitative data; and the predominant concern with the psychological aspects of the condition to the detriment of the social dimensions involved. Using the International Classification of Impairments, Disabilities and Handicaps (ICIDH) as its conceptual scaffold, the paper then goes on to argue that a sociological perspective is both a necessary and an essential complement to existing research in this area in order to achieve a fuller understanding of chronic respiratory illness-disability and its sequelae. Finally, the paper attempts to offer some possible reasons why chronic respiratory illness and disability have received relatively little attention from within the social sciences and concludes with some reflections and suggestions on possible future developments in research into chronic respiratory illness and disability from within the social sciences. (91 references) AA

Address for reprint requests: 13 Mere Road, Shepperton, Middlesex TW17 9BN, England

REFERENCE NUMBER 55

Au: Yew, Elizabeth; Kropsky, Benjamin A.; Neufeld, Richard R.; Libow, Leslie S.

Ti: **The Clinical Utility of a Comprehensive Periodic Assessment Form for the Geriatric Rehabilitation Patient**

So: *Gerontologist* 29(2):263-267, 1989

The Comprehensive Periodic Assessment Form is a new format used to document a patient's rehabilitation progress. It is a nonnarrative, semigraphical form in which many sheets of progress notes from a variety of disciplines are digested on one page. Mobility, ADL, mental, and medical status over time can be ascertained at a glance. The form has special utility for the aged patient experiencing rehabilitation treatment. (9 references) AA

Address for reprint requests: The Jewish Home and Hospital for Aged, 120 West 160 Street, New York, New York 10025

REFERENCE NUMBER 56

Au: Yu, Elena S.H.; Liu, William T.; Levy, Paul; Zhang, Ming-Yuan; Katzman, Robert; et al.

Ti: **Cognitive Impairment Among Elderly Adults in Shanghai, China**

So: *Journal of Gerontology* 44(3):S97-S106, 1989

This study reports the methods and initial findings of the first longitudinal study of Alzheimer's disease and dementia in China. A probability sample of 5,055 noninstitutionalized elderly persons in Shanghai was tested directly during the first phase of the study using a Chinese version of the Mini-Mental State

Examination (MMSE). Details of sampling design and data collection procedures are described. Overall, some 4.1 percent of adults 55 years or older may be classified as having severe cognitive impairment, and 14.4 percent are mild cases. The rates for females are higher than for males by a ratio of 3.75 in the severe category and 2.6 in the mild group. Within each age group, cognitive impairment rates vary by education. Multiple logistic regression was used to examine, within each age group, the nature of the association between the presence of a cognitive impairment and educational level, controlling for sex. The results showed that educational attainment has a highly significant inverse relationship with prevalence of cognitive impairments (severe vs. others). On the other hand, when educational attainment was controlled for in the logistic regression model, sex was significantly associated with prevalence of cognitive disorders for the age groups 65-74 and 75 years or older, but not for the group 55-64 years. These findings suggest the impact the basic educational deficits have on human cognitive functioning as measured through tests like the MMSE. Cross tabulations of impairment rates according to marital status, economic status, and health-related problems are also presented. (30 references) AA

Address for reprint requests: Pacific Asian American Mental Health Research Center, 1033 W. Van Buren Street, 7-N, Chicago, Illinois 60607

REFERENCE NUMBER 57

Au: Zautra, Alex J.; Okun, Morris A.; Robinson, Sharon E.; Lee, Douglas; Roth, Sanford H.
Ti: **Life Stress and Lymphocyte Alterations Among Patients With Rheumatoid Arthritis**
So: *Health Psychology* 8(1):1-14, 1989

The relation between life stress and immune parameters was investigated for 33 female rheumatoid arthritis (RA) patients interviewed during three routine monthly clinic checkups. Life stress from major and minor events, coping efficacy, and self-reported psychological distress were assessed, and immunofluorescence of T-cells and B-cells was performed on the blood drawn during each visit. Small stressful events were positively related to the proportion of circulating B-cells, psychological distress was inversely related to proportion of circulating T-cells, and major life events were associated with lower T-helper/T-suppressor cell ratios. (20 references) AA

Address for reprint requests: Department of Psychology, Arizona State University, Tempe, Arizona 85287

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.

Acta Psychiatrica Scandinavica	79(4-6)	Health Services Research	23(6)24(1-2)
American Behavioral Scientist	32(3-5)	Health Values	13(3)
American Economic Review	79(1-3)	Inquiry	26(2)
American Journal of Economics and Sociology	48(2)	International Journal of Aging and Human Development	28(3)(4)
American Journal of Epidemiology	129(1-6)	International Journal of Epidemiology	18(2)(Suppl 1)(Suppl 2)
American Journal of Medicine	86(4-6);Suppl(4A)(6A)	International Journal of Health Services	19(2)
American Journal of Orthopsychiatry	59(2)	International Journal of Technology Assessment in Health Care	5(1-2)
American Journal of Psychiatry	146(1-6)	Journal of Aging and Health	1(2)
American Journal of Psychology	102(2)	Journal of Allied Health	18(4)
American Journal of Public Health	79(1-6)	Journal of Applied Behavioral Science	25(2-3)
American Journal of Sociology	94(6)	Journal of Applied Psychology	74(2-3)
American Political Science Review	83(1)(2)	Journal of Behavioral Medicine	12(1-3)
American Psychologist	44(4-6)	Journal of Clinical Epidemiology	42(4-6)
American Sociological Review	54(2)(3)	Journal of Community Health	14(1-2)
Archives of Environmental Health	44(1-3)	Journal of Consulting and Clinical Psychology	57(1-2)
Archives of Gerontology and Geriatrics	8(3)	Journal of Epidemiology and Community Health	43(2)
Archives of Physical Medicine and Rehabilitation	70(4-6)(5. Suppl)	Journal of Experimental Child Psychology	47(1-3)
Australian and New Zealand Journal of Psychiatry	23(2)	Journal of Experimental Social Psychology	25(3)
Behavioral Medicine	15(2)	Journal of Family Practice	28(1-6)
Behavioral Science	34(2)	Journal of Gerontology	44(3)
British Journal of Psychiatry	154(4-6)	Journal of Health and Social Behavior	30(2)
British Journal of Psychology	80(2)	Journal of Health Economics	8(2)
Canadian Journal of Behavioral Science	21(2)	Journal of Health, Politics, Policy, and Law	14(2)
Canadian Journal of Public Health	80(1-3)	Journal of Nervous and Mental Disease	177(4-6)
Canadian Medical Association Journal	140(7-12)	Journal of Pediatrics	114(1)(4-6)
Child Welfare	68(3)	Journal of Policy Analysis and Management	8(2)
Clinical Psychology Review	9(3)	Journal of Policy Modeling	11(1-2)
Cognitive Psychology	21(2)	Journal of Political Economy	97(2-3)
Cognitive Therapy and Research	13(2)(3)	Journal of Psychopathology and Behavioral Assessment	11(1-2)
Community Mental Health Journal	25(2)	Journal of Psychosocial Oncology	7(1-2)
Family and Community Health	12(2)	Journal of Public Health Policy	10(2)
Geriatrics	44(4-6)	Journal of School Health	59(1-5)
Gerontologist	29(2-3)	Journal of School Psychology	27(2)
Health Affairs	8(1)	Journal of Social Policy	18(2)
Health Care Financing Review	10(3-4)		
Health Education Quarterly	16(2)		
Health Policy	11(2-3)		
Health Psychology	8(1-3)		

Journal of the American Geriatrics Society	37(4-6)	Psychological Record	39(1-2)
Medical Care	27(4-6)	Psychology and Aging	4(1-2)
Milbank Quarterly	67(1-2)	Psychosocial Rehabilitation Journal	12(4)
Multivariate Behavioral Research	24(1-2)	Psychosomatic Medicine	51(3)
New England Journal of Medicine	320(14-26)	Psychosomatics	30(2)
New York Academy of Medicine Bulletin	65(4-5)	Public Health Reports	104(3)
Operations Research	37(1-3)	Quality Review Bulletin	15(5-6)
Organization Studies	10(1-2)	Review of Economics and Statistics	71(2)
Organizational Behavior and Human Decision Processes	43(2-3)	Science, Technology and Human Values	14(2)
Perspectives in Biology and Medicine	32(3-4)	Social Forces	67(3-4)
Philosophy and Public Affairs	18(2)	Social Indicators Research	21(2-3)
Policy Sciences	22(2)	Social Problems	36(2-3)
Policy Studies Journal	17(3)	Social Psychology Quarterly	52(2)
Policy Studies Review	8(2-3)	Social Science and Medicine	28(7-12)
Preventive Medicine	18(3)	Social Science Research	18(1-2)
Psychological Medicine	19(1-2)	Social Service Review	63(1-2)
		Socio-Economic Planning Sciences	23(3)
		Sociological Methods and Research	17(4)
		Sociology of Health and Illness	11(2)
		Statistics in Medicine	8(3-6)

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 April through June 1989 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 that have been classified under the medical subject heading "health status indicators" by the National Library of Medicine (NLM) and that were entered into NLM's SDILINE or FILE HEALTH databases in April, May or June 1989. Citations are printed with only slight modification of format, in the order and form in which they appear in NLM's files. Following NLM's convention, titles which are enclosed in brackets indicate that the article is published in some language other than English.

REFERENCE NUMBER 58

Au: Nelson EC ; Berwick DM

Ti: **The measurement of health status in clinical practice.**

So: Med Care 1989 Mar;27(3 Suppl):S77-90

Functional status measurement and the assessment of health status are reaching their maturity as technical disciplines. Good tools exist that meet requirements such as brevity, validity, reliability, ease of administration, and ease of scoring, which makes them potentially suitable for use in clinical practice. Despite this progress, widespread adoption of measurement tools has not occurred in the clinical world. The authors analyze both the potential and the barriers to use of health assessment tools in practice and note the need for better scientific evidence of their clinical utility, as opposed to their information content. Dissemination of these tools among practitioners will require, above all, evidence and conviction that the use of measurement instruments will actually enhance the very health status outcomes they assess.

Address for reprint requests: Quality Resource Group, Hospital Corporation of America, Nashville, TN 37202-0550.

REFERENCE NUMBER 59

Au: Mulley AG Jr

Ti: **Assessing patients' utilities. Can the ends justify the means?**

So: Med Care 1989 Mar;27(3 Suppl):S269-81

Each of the elements of a utility assessment strategy—defining and describing health states of interest, identifying subjects, choosing a scaling task, aggregating across subjects, determining reliability and validity—is controversial. The controversy is in part explained by the interdisciplinary nature of the problem; different disciplinary conceptualizations of utility lead to different priorities for methodologic problem solving. Controversy is further explained by widely divergent potential applications of utility assessments, including individual decisions made with and without (or by) an agent, and decisions made for populations that may be homogeneous or heterogeneous with regard to utilities for the same health states. Issues can be clarified by focusing on the purpose of the utility assessment and, in the case of clinical decisionmaking, on the most relevant disease-specific outcomes. The prostatectomy decision is an example. Although questions of measurement validity need continuing attention, more attention should be paid to validating uses of utility assessments: Can utility assessments distinguish prospectively, among patients who subsequently experience the same health outcome, those for whom it is associated with a high or low level of Well-Being? Can utility assessments be used to predict behavior? Can a decision process that includes utility assessments affect decisions in a manner that improves overall Well-Being? Approaches to such questions are complicated by changes in utilities over time, departures from the normative model of decisionmaking, the effects of decisionmaking responsibility, and biases introduced by the decisionmaking process.

Address for reprint requests: General Internal Medicine Unit, Massachusetts General Hospital, Boston, MA 02114.

REFERENCE NUMBER 60

Au: Deyo RA ; Patrick DL

Ti: **Barriers to the use of health status measures in clinical investigation, patient care, and policy research.**

So: Med Care 1989 Mar;27(3 Suppl):S254-68

Despite growing interest and sophistication in health status assessment, these measures are not widely used in settings where they would be appropriate. The reasons include conceptual, methodologic, practical, and attitudinal barriers, some of which are common to a variety of applications (for example, clinical research, patient care, or policy research). These barriers include skepticism about the validity and importance of self-rated health; preferences for physiologic outcomes or death rates; unfamiliarity with questionnaire scores; a paucity of direct instrument comparisons to aid in selection; and the costs of pilot testing, data collection, and data manipulation. In clinical trials, the uncertain responsiveness of questionnaire instruments to small but clinically important changes may be of particular concern. For patient care, additional barriers are posed by the need for rapidly processing data, the need for providing highly understandable results to clinicians, and clinicians' uncertainty about how to use the information. In policy research, there is often insufficient time for responding (with health status measurement) to decisionmakers' needs, and many have reservations about concepts such as quality-adjusted life years that arise from health status measurement. To facilitate a better intuitive grasp of health status scores, more comparisons with traditional clinical scales and physiologic measures are needed. More effort should be given to demonstrating (and improving) the responsiveness of scales to clinically important changes and to developing very brief questionnaires. Better education of health professionals about these measurement techniques is needed, as well as better methods of presenting results. Finally, a "laboratory" to provide measurement services to investigators and clinicians may make use of these scales more attractive.

Address for reprint requests: Seattle Veterans Administration Medical Center, Seattle, WA 98108.

REFERENCE NUMBER 61

Au: Patrick DL ; Deyo RA

Ti: **Generic and disease-specific measures in assessing health status and quality of life.**

So: Med Care 1989 Mar;27(3 Suppl):S217-32

Application of generic and specific measures of health status and quality of life to different diseases, conditions, states, and populations is increasing. Four strategies for using these measures are separate generic and specific measures, modified generic measures, disease-specific supplements, and batteries. The preferred strategy depends on project aims, methodological concerns, and practical constraints. Generic measures are necessary to compare outcomes across different populations and interventions, particularly for cost-effectiveness studies. Disease-specific measures assess the special states and concerns of diagnostic groups. Specific measures may be more sensitive for the detection and quantification of small changes that are important to clinicians or patients. Comparison studies are needed of the validity, reliability, and responsiveness of generic and disease-specific measures in the same population and in minority and age-specific groups. (95 references)

Address for reprint requests: Department of Health Services, School of Public Health and Community Medicine, University of Washington, Seattle, WA 98195.

REFERENCE NUMBER 62

Au: Breslow L

Ti: **Health status measurement in the evaluation of health promotion.**

So: Med Care 1989 Mar;27(3 Suppl):S205-16

A step beyond treatment and even the prevention of disease is coming onto the health agenda. It is health promotion—"the advancement of Well-Being and the avoidance of health risks by achieving the optimal levels of the behavioral, societal, environmental and biomedical determinants of health." It differs from medical service in that the latter is directed largely toward overcoming poor health, disequilibrium with one's environment. Health promotion is aimed at maintaining the level of health and, insofar as possible, strengthening the potential (resources) for health. The emergence of health promotion raises an issue for those concerned with health status measurement: Whether we consider health as having only biologic elements as traditionally understood in biomedical science, and role (performance) elements as traditionally understood in sociomedical science; or whether we add to these considerations a view of health as the dynamic equilibrium of individuals or groups of people with their environment, their capacity to live physically, mentally, and socially. The latter view entails measuring the health of people on a continuum extending from "perfect" harmony with one's environment and maximum potential for responding to adversities, on the one hand, to extreme invalidism and no reserves, that is, the premorbid state, at the other extreme. That view also entails expanding attention to the whole population, not just the sick. It also means considering the relative emphasis to be given conceptual and methodologic work, individual versus community responsibilities for health, and the alleged medicalization of life. (20 references)

Address for reprint requests: School of Public Health, University of California, Los Angeles, CA 90024-3511.

REFERENCE NUMBER 63

Au: Feeny DH ; Torrance GW

Ti: **Incorporating utility-based quality-of-life assessment measures in clinical trials. Two examples.**

So: Med Care 1989 Mar;27(3 Suppl):S190-204

The utility approach to the measurement of health-related quality of life is discussed, and its theoretical foundations and compatibility with economic evaluation are explained. The advantages of the approach include its generalizability, comprehensiveness, ability to integrate mortality and morbidity effects, ability to represent multiple viewpoints, and its incorporation of time and risk preferences in the scores. Disadvantages include interviewer administration, limitations on obtaining scores from all types of subjects, some lack of precision, and attenuated clinical sensibility. Use of the utility approach as an outcome measure in two recent clinical trials is also described. In a trial of an oral gold compound for arthritis, the utility measures were responsive and added information to that from standard clinical and other quality-of-life measures. The utility approach and clinical decisionmaking are being used in an on-going trial of two procedures for prenatal diagnosis in which major potential differences include quality-of-life effects. The comprehensiveness of the utility approach overcomes difficulties in interpreting results from more narrowly focused psychosocial measures of outcome. In sum, the utility model provides a reliable, valid, and responsive approach to measuring quality of life as an outcome in clinical trials.

Address for reprint requests: Department of Economics, McMaster University, Hamilton, Ontario, Canada.

REFERENCE NUMBER 64

Au: Kazis LE ; Anderson JJ ; Meenan RF
Ti: **Effect sizes for interpreting changes in health status.**
So: Med Care 1989 Mar;27(3 Suppl):S178-89

Health status measures are being used with increasing frequency in clinical research. Up to now the emphasis has been on the reliability and validity of these measures. Less attention has been given to the sensitivity of these measures for detecting clinical change. As health status measures are applied more frequently in the clinical setting, we need a useful way to estimate and communicate whether particular changes in health status are clinically relevant. This report considers effect sizes as a useful way to interpret changes in health status. Effect sizes are defined as the mean change found in a variable divided by the standard deviation of that variable. Effect sizes are used to translate "the before and after changes" in a "one group" situation into a standard unit of measurement that will provide a clearer understanding of health status results. The utility of effect sizes is demonstrated from four different perspectives using three health status data sets derived from arthritis populations administered the Arthritis Impact Measurement Scales (AIMS). The first perspective shows how general and instrument-specific benchmarks can be developed and how they can be used to translate the meaning of clinical change. The second perspective shows how effect sizes can be used to compare traditional clinical measures with health status measures in a standard clinical drug trial. The third application demonstrates the use of effect sizes when comparing two drugs tested in separate drug trials and shows how they can facilitate this type of comparison. Finally, our health status results show how effect sizes can supplement standard statistical testing to give a more complete and clinically relevant picture of health status change. We conclude that effect sizes are an important tool that will facilitate the use and interpretation of health status measures in clinical research in arthritis and other chronic diseases.

Address for reprint requests: Multipurpose Arthritis Center, Boston University School of Medicine, Boston, MA 02118.

REFERENCE NUMBER 65

Au: Bergner M
Ti: **Quality of life, health status, and clinical research.**
So: Med Care 1989 Mar;27(3 Suppl):S148-56

Although interest is increasing in measurement of quality of life, health status, and functional status in clinical research, most often the primary focus of the research is traditional measures of mortality and morbidity. Quality-of-life assessments are usually added as an afterthought once the design, data collection, and analytic techniques have been specified. When nonmedical outcomes are considered, they are thought of as quality-of-life outcomes. Quality of life is not well conceptualized in the medical and health literature. In addition, clinical researchers are searching for a single best measure of quality of life. Lack of information about clinical significance and sensitivity and uncertainties about the advantages of different administration strategies are impediments to use of developed measures. These issues and problems are discussed and suggestions made about procedures and investigations that could provide guidance. (24 references)

Address for reprint requests: Department of Health Policy and Management, Johns Hopkins University, School of Hygiene and Public Health, Baltimore, MD 21205.

REFERENCE NUMBER 66

Au: Steinwachs DM

Ti: **Application of health status assessment measures in policy research.**

So: Med Care 1989 Mar;27(3 Suppl):S12-26

The application of health status measures in policy research relies considerably on patterns of mortality, life expectancy, and health status indicators, such as hospital readmission and institutionalization rates. In recent years the state of the art in health status measurement has advanced substantially with the development of multidimensional measures with established reliability and validity. These newer measures have not found wide application in policy research. This may reflect many factors; including the complexity of these measures, the cost of data collection, and the perception that the health status scores are not easily interpreted. It also may reflect the perceived value of simpler and unidimensional measures of health that can be translated more readily into estimates of the need for health care services. A framework is proposed for the application of health status measures in policy research. This framework emphasizes the relationship between health status and the need for care, the measurement of unmet needs for care, and the role of health policy in assuring that services are available and appropriate to meet the needs for care. A case study is used to illustrate some of the issues in using health status indicators to measure needs for care and outcomes. (54 references)

Address for reprint requests: Health Services Research and Development Center, Johns Hopkins University School of Hygiene and Public Health, Baltimore, MD 21205.

REFERENCE NUMBER 67

Au: Reisine ST ; Fertig J ; Weber J ; Leder S

Ti: **Impact of dental conditions on patients' quality of life.**

So: Community Dent Oral Epidemiol 1989 Feb;17(1):7-10

Quality-of-life measures have rarely been used in dentistry to assess oral health status. The purpose of this paper is to assess the utility of using standard indicators to measure the impacts of dental conditions on patients' quality of life. Quality of life was conceptualized as a multidimensional construct including three major aspects: Social functioning, measured by the Sickness Impact Profile; Well-Being, measured by the Gill Well-Being Scale, Spielberger State/Trait Anxiety Scale, and the Corah Dental Anxiety Scale; and symptoms, measured by the Kiyak Oral Functioning Scale, the McGill Pain Questionnaire, and the West Haven Multidimensional Pain Inventory. There were 152 patients recruited from private dental practices consisting of 48 TMJ, 33 periodontal, 23 denture, and 48 recall patients. Patients in the first three groups reported numerous impacts on quality of life and the impacts were particularly severe for the TMJ patients. The indicators used were sensitive to differences among the four groups and hold promise for further development of quality-of-life indicators for use in epidemiologic surveys and clinical dental trials.

Address for reprint requests: University of Connecticut School of Dental Medicine, Farmington, CT.

REFERENCE NUMBER 68

Au: Guyatt G ; Mitchell A ; Irvine EJ ; Singer J ; Williams N ; Goodacre R ; Tompkins C

Ti: **A new measure of health status for clinical trials in inflammatory bowel disease.**

So: Gastroenterology 1989 Mar;96(3):804-10

We have developed a measure of subjective health status (quality of life) for patients with inflammatory bowel disease (IBD). Ninety-seven patients with IBD described problems they had experienced as a result of the disease; the 32 most frequent and important items were included in the Inflammatory Bowel Disease Questionnaire (IBDQ). Sixty-one IBD patients were evaluated twice. One month separated the evaluations, at which disease activity indices, the IBDQ, and a number of other questionnaires were administered. Reproducibility studies in 19 stable patients showed improvement in scores, but also a small

within-person standard deviation. Responsiveness studies revealed large changes in scores in patients who had improved or deteriorated and suggested that the IBDQ was more responsive than a general health status measure. Responsiveness appeared greater in patients with ulcerative colitis than in those with Crohn's disease. Predicted and observed correlations between changes in IBDQ score and changes in other measures were similar. We conclude that although further testing is required, particularly in examining the relation between changes in the IBDQ and changes in the activity of Crohn's disease, the IBDQ shows promise as a measure of health status for clinical trials in IBD.

Address for reprint requests: School of Nursing, Department of Clinical Epidemiology and Biostatistics, McMaster University, Hamilton, ON, Canada.

REFERENCE NUMBER 69

Au: Epstein AM ; Hall JA ; Tognetti J ; Son LH ; Conant L Jr

Ti: **Using proxies to evaluate quality of life. Can they provide valid information about patients' health status and satisfaction with medical care?**

So: Med Care 1989 Mar;27(3 Suppl):S91-8

Instruments using interview data to measure health status have been increasingly used to measure patient outcomes. To assess the potential utility of proxy responses about health status when subjects are unable to respond, the authors compared the responses of 60 subject and proxy pairs on instruments measuring overall current health, functional status, social activity, emotional health, and satisfaction with medical care. Proxies were asked to respond as they thought the subject would. Subject and proxy responses were strongly correlated with each other for overall health, functional status, social activity, and emotional health (P less than .001), and moderately correlated for satisfaction (P less than .005). Proxies reported lower emotional health and satisfaction than did subjects (P less than .005). Proxy and subject mean responses were generally similar for overall health, functional status, and social activity. However, those proxies who spent more time per week helping the subject rated the subject's functional status and social activity as more impaired than did the subject (P less than .05). Subjects who had poorer overall health tended to rate their health relatively lower than did the proxies (P less than .05). These results suggest that use of proxies intermingled with subjects to measure health status through interview may lead to biased results.

Address for reprint requests: Department of Health Policy and Management, Harvard School of Public Health, Boston, MA 02115.

REFERENCE NUMBER 70

Au: Erickson P ; Kendall EA ; Anderson JP ; Kaplan RM

Ti: **Using composite health status measures to assess the nation's health.**

So: Med Care 1989 Mar;27(3 Suppl):S66-76

Research in progress at the National Center for Health Statistics for evaluating the usefulness of composite measures of health status for assessing the nation's health is described. Three measures suitable for use in the general population, the Health Insurance Experiment-Functional Limitations (HIE-FL), the Health Utility Index (HUI), and the Quality of Well-Being (QWB) Scale, have been mapped to data collected in the 1980 National Health Interview Survey (NHIS). Analysis using current algorithms for making composite function status measures according to the QWB methods suggests that traditional single indicators of health tend to overestimate the level of health by about 10 percent. When symptoms and problems are added to the composite function score, the overestimate as measured by the single indicator is at least 50 percent. The authors are continuing to validate these algorithms, to develop similar ones for the HIE-FL and HUI, and to extend the analysis to data collected in 1977, 1979, and 1984. Current results

indicate that to realize fully the benefits of composite measures, well-established, valid, and reliable measures of health-related quality of life should be included as part of the regular NHIS data collection procedures.

Address for reprint requests: Clearinghouse on Health Indexes, National Center for Health Statistics, Hyattsville, MD 20872.

REFERENCE NUMBER 71

Au: Lewis CC ; Pantell RH ; Kieckhefer GM

Ti: **Assessment of children's health status. Field test of new approaches.**

So: Med Care 1989 Mar;27(3 Suppl):S54-65

The assessment of children's health status presents unique difficulties. These include parent-child differences in reports of functioning, knowledge of what constitutes age-appropriate functioning, obtainment of accurate information for child, and demonstration of the predictivity of health status measures. Recent measures (the Functional Status II-R and instruments from the RAND Health Insurance Experiment) address physical, social, and psychologic domains of children's health. The authors modified these instruments to develop short (7 and 14 items) questionnaires (RAND, FSQ) to assess child health. Scoring on these questionnaires was compared with traditional measures of illness severity and medical service utilization. The authors also evaluated coding illness-specific and general health limitations (FSQ-S and FSQ-G, respectively). Patients included the parents of 113 children with chronic illness (100 asthmatics). Measure stability was evaluated over a 6-month period in a subset of patients. Internal consistency (Cronbach's alpha) of the seven-item RAND measure was .78, the FSQ-S .78, and the FSQ-G .73 to .89 during repeated samplings over 6 months. The FSQ-S and RAND seven-item measure were moderately correlated (.47, P less than .001). The authors observed significant correlations among alternate codings of the FSQ and RAND and between the FSQ-S, FSQ-G, RAND, and severity measure with traditional indices of medical service utilization. Parents were more likely to attribute certain functional status problems (for example, being tired) to illness than they were other problems (such as moodiness or interest in things). The findings demonstrate that these measures have acceptable psychometric properties and provide preliminary evidence of construct validity in a group of young children with asthma. Using general and specific measures will provide differing pictures of a child's functioning. No single measure completely taps the impact of illness as measured by a panel of traditional indicators of illness burden and medical service utilization.

Address for reprint requests: Department of Pediatrics and Psychiatry, University of California, San Francisco, CA 94143-0314.

REFERENCE NUMBER 72

Au: Temkin NR ; Dikmen S ; Machamer J ; McLean A

Ti: **General versus disease-specific measures. Further work on the Sickness Impact Profile for head injury.**

So: Med Care 1989 Mar;27(3 Suppl):S44-53

Three modifications devised to make the Sickness Impact Profile (SIP) more sensitive to head injury are evaluated in 202 head-injured and 132 general trauma patients 1 month and 12 months after injury. The modifications consist of adding items, deleting nonapplicable items, and reweighting areas of function. Each of the modifications, and especially all three combined, slightly but significantly improve discrimination of head-injured and comparison subjects and increase correlations with neurologic and neuropsychologic severity indexes. These slight improvements occur more often at 12 months than at 1 month and among those without rather than with preexisting conditions. No improvements are found in the ability to classify patients into subgroups. The modifications fail to make improvements sufficiently large or consistent to provide a practical advantage over the SIP. The standard SIP provides a reasonable measure

of psychosocial functioning following head injury. It relates to head injury and other system injury severity and reflects recovery with time. The SIP score relates to emotional functioning even after injury, severity has been taken into account. Until other factors, such as emotional status and responses style, are better controlled, little benefit is likely to be obtained from creating disease-specific psychosocial measures.

Address for reprint requests: Department of Neurological Surgery, University of Washington, Seattle, WA 98104.

REFERENCE NUMBER 73

Au: Kaplan RM ; Anderson JP ; Wu AW ; Mathews WC ; Kozin F ; Orenstein D
Ti: **The Quality of Well-being Scale. Applications in AIDS, cystic fibrosis, and arthritis.**
So: Med Care 1989 Mar;27(3 Suppl):S27-43

The Quality of Well-Being (QWB) Scale combines preference-weighted measures of symptoms and functioning to provide a numerical point-in-time expression of Well-Being that ranges from zero (0) for death to 1.0 for asymptomatic optimum functioning. The QWB includes three scales of function: Mobility, physical activity, and social activity. Each step of these scales is associated with preference weights. Preference adjustments for symptoms are also included. This paper describes how this general system was used to evaluate outcomes in three different clinical conditions: Acquired immune deficiency syndrome (AIDS), cystic fibrosis, and arthritis. In one study, the QWB was administered to 31 patients participating in evaluation of azidothymidine (AZT) treatment for AIDS. The QWB system demonstrated substantial benefits of AZT treatment in comparison to placebo. In a second study, the QWB and a series of pulmonary function measures were administered to 44 patients with cystic fibrosis. The QWB was demonstrated to be significantly correlated with measures of pulmonary function, including FEV1 and maximal midexpiratory flow rate (MMEFR). In addition, there were significant associations between the QWB and measures of exercise tolerance. In the third study, the QWB and an arthritis-specific measure were administered to 83 arthritis patients before and after their treatment. The QWB was at least as capable of detecting clinical change in this population as was the disease-specific measure. For all three conditions, the QWB considered side effects and benefits of treatment in a common unit. Clinical trial data are cited to suggest that the QWB is a valuable outcome measure in arthritis treatment evaluation. We conclude that the QWB has substantial validity as a general health outcome measure and that the system can be used with different populations.

Address for reprint requests: Division of Health Care Sciences, University of California, San Diego, La Jolla, CA 92093.

REFERENCE NUMBER 74

Au: Hall JA ; Epstein AM ; McNeil BJ
Ti: **Multidimensionality of health status in an elderly population. Construct validity of a measurement battery.**
So: Med Care 1989 Mar;27(3 Suppl):S168-77

Although health is generally accepted to be a multidimensional construct, the relationship among various domains has not been well defined. To understand this issue better we used principal components analysis to examine the relations among a set of health status measures gathered on 590 elderly members of a health maintenance organization (HMO). These included functional health, emotional health, social activity within and outside of the family, and cognitive functioning (all based on patient interview), physicians' ratings of patients' health, and chart-derived data on physiologic health. Support was obtained for the umbrella concept of "health" as well as for six subcomponents: Functional health, emotional health, physiologic health, both kinds of social activity, and cognitive functioning. Patients' ratings of their overall physical and mental health were related to functional, physiologic, and emotional health factors,

whereas physicians' ratings of overall physical and mental health were never related to the emotional health factor. This suggests that patients may hold a broader frame of reference in gauging overall health than physicians do.

Address for reprint requests: Department of Psychology, Northeastern University, Boston, MA 02115.

REFERENCE NUMBER 75

Au: Rothman ML ; Hedrick S ; Inui T

Ti: **The Sickness Impact Profile as a measure of the health status of noncognitively impaired nursing home residents.**

So: Med Care 1989 Mar;27(3 Suppl):S157-67

The Sickness Impact Profile (SIP) is a multidimensional, behaviorally based measure of the health status that has been successfully used in a wide range of applications. The characteristics of this measure have not been assessed with nursing home residents. The purpose of this study was to assess the feasibility, reliability (internal consistency), validity, and comprehensiveness of the SIP as a measure of the health status of a selected group of nursing home residents. Responses of 168 veterans residing in community and VA nursing homes to a questionnaire consisting of the SIP, Index of Activities of Daily Living, Barthel Index, Life Satisfaction Index Z, and the Philadelphia Geriatric Center Morale Scale were obtained. In general, the respondents correctly interpreted instructions; reliability and validity were supported; and the SIP was found to provide a comprehensive assessment of physical function. Adding a measure of psychologic Well-Being to a study protocol involving this population may, however, provide additional useful information regarding this construct.

Address for reprint requests: Northwest Health Services Research and Development Field Program, Seattle Veterans Administration Medical Center, Seattle, WA 98108.

REFERENCE NUMBER 76

Ti: **Advances in health status assessment: conference proceedings. July 13-15, 1988, Menlo Park, California.**

So: Med Care 1989 Mar;27(3 Suppl):S1-294

REFERENCE NUMBER 77

Au: Lohr KN

Ti: **Advances in health status assessment. Overview of the conference.**

So: Med Care 1989 Mar;27(3 Suppl):S1-11

Although the art and science of health status measurement have a considerable history that is in some ways as old as the healing arts themselves, interest and developments in this field have accelerated in the last two decades. To take advantage of this encouraging environment, the Henry J. Kaiser Family Foundation sponsored its second conference on Advances in Health Status Assessment. It had two major goals: First, to let developers and potential users of health assessment tools explore further the conceptual and methodologic issues of particular concern to them; second, to highlight advances in applying these tools to clinical practice, clinical and biomedical research, and policy research. This monograph reports on the proceedings of that conference: Three overviews and nine empirical reports in the above-mentioned areas, one special report on health promotion, and four studies on particular methodologic issues (barriers to the use of health status assessment instruments, the advantages and limitations of generic and disease-specific measures, incorporating patient utilities into health status measures, and discounting).

The conference highlighted both the considerable advances made in this field in the recent past and the numerous conceptual, methodologic, and practical problems yet to be resolved.

Address for reprint requests: Institute of Medicine, National Academy of Sciences, Washington, DC 20418.

REFERENCE NUMBER 78

Au: Golaszewski T ; Lynch W ; Clearie A ; Vickery DM

Ti: **The relationship between retrospective health insurance claims and a health risk appraisal-generated measure of health status.**

So: J Occup Med 1989 Mar;31(3):262-4

This research examined the relationship between a measure of health status (defined as the health index—the difference between actual and appraised ages) derived from a health risk appraisal and retrospective health insurance claims taken from one cooperating work organization. A model was defined consisting of 3-year retrospective medical claims as the criterion and age and the health index as predictors. Using a cube-root transformation of medical claims, a significant inverse relationship for age and the health index was identified for men. No relationships were found for women. It was concluded that, for men when age is held constant, a negative relationship exists between retrospective medical claims and a health risk appraisal-generated health status indicator, the health index.

Address for reprint requests: Center for Corporate Health Promotion, Inc., Reston, VA 22091.

REFERENCE NUMBER 79

Au: Ferraro KF

Ti: **Reexamining the double jeopardy to health thesis.**

So: J Gerontol 1989 Jan;44(1):S14-6

The purposes of this article are twofold: To clarify the evaluation of the double jeopardy thesis and to evaluate two apparently contradictory sets of results on the double jeopardy thesis to health derived from the same data (National Council on the Aging, 1975). The results offer no support for the double jeopardy thesis based on a subjective assessment of health problems. Both logistic regression analysis and multiple discriminant analysis were used to estimate the relationships among the variables considered.

Address for reprint requests: Department of Sociology, Northern Illinois University, DeKalb, IL.

AUTHOR INDEX

37

Adler, Gerald S.	52	Gnatz, Steven	40
Anderson, J.J.	64	Golaszewski, T.	78
Anderson, J.P.	70,73	Goldman, Paula A.	53
Ardia, Alfredo	1	Goodacre, R.	68
Barsky, Arthur J.	53	Grace, E.	51
Battaglia, Angelo	1	Greenfield, Sheldon	45
Bellamy, Paul E.	11	Grip, Jeffrey C.	33
Bennett, K.	51	Guralnik, Jack M.	17
Bensen, W.	51	Guyatt, Gordon H.	18,68
Bergner, M.	65	Haga, Hiroshi	26
Berwick, Donald M.	53,58	Hall, J.A.	69,74
Bombardier, C.	51	Harrington, Joseph E. Jr.	19
Bonardi, Elisa	2	Hedrick, S.	75
Branch, Laurence G.	3,24,34,44,46	Hinrichs, James V.	42
Brennan, Penny L.	4	Hirschman, Albert O.	20
Breslow, L.	62	Homel, Ross	21
Bruni, Giancarlo	1	Horowitz, Amy	3
Buck, Karen A.	46	Hume, Anne L.	22
Burns, Ailsa	21	Hunt, Linda M.	23
Calkins, David R.	45	Inui, T.	75
Carr, Cheryl	3	Irvine, E.J.	68
Charlson, Mary	18	Irwin, Susan	23
Clearie, A.	78	Jette, Alan M.	45
Conant, L. Jr.	69	Jordan, Brigitte	23
Cox, James C.	5	Kaasa, Stein	31
Craik, Rebecca	37	Kane, Robert L.	13,14,15
Cupples, L. Adrienne	34	Kaplan, George A.	17
Deppe, Hans-Ulrich	6	Kaplan, R.M.	70,73
Deyo, R.A.	18,60,61	Katzman, Robert	56
Dikmen, S.	72	Kazis, L.E.	64
Durand-Zaleski, Isabelle	50	Keeler, Emmett B.	39
Eddy, David M.	7	Keil, J.E.	24
Ensel, Walter M.	30	Kendall, E.A.	70
Epstein, A.M.	69,74	Kieckhefer, G.M.	71
Epstein, Seth	5	Kinney, Jennifer M.	25
Erickson, P.	70	Knott, Kathryn	37
Fabian, Ellen S.	8	Koyano, Wataru	26
Feeny, D.H.	63	Kozin, F.	73
Feltin, Marie	34	Kozma, Albert	49
Ferraro, K.F.	79	Krause, Neal	29
Fertig, J.	67	Kropsky, Benjamin A.	55
Frank, Robert H.	9,10	Larsson, Ullabeth Satterlund	27
Frankl, David	11	Leder, S.	67
Fries, James F.	12	Lederman, Ruth I.	34
Froberg, Debra G.	13,14,15	Lee, Douglas	57
Gazes, P.C.	24	Lemke, Sonne	4
Gelberg, Lillian	16	Levine, Mark N.	18
Ghoneim, Mohamed M.	42	Levy, Haim	28
		Levy, Paul	56

Lewis, C.C.	71	Ragheb, Nawal E.	46
Liang, Jersey	29	Reisine, S.T.	67
Libow, Leslie S.	55	Robinson, Sharon E.	57
Lin, Nan	30	Rogers, Andrei	44
Linn, Lawrence S.	16	Rogers, Richard G.	44
Liu, William T.	56	Roth, Sanford H.	57
Lohr, K.N.	77	Rothman, M.L.	75
Lynch, W.	78	Rubenstein, Lisa V.	45
Machamer, J.	72	Rust, P.F.	24
Manning, Willard G.	39	Sacchetti, Gabriele	1
Manton, Kenneth G.	52	Saljo, Roger	27
Markides, Kyriakos S.	29	Satariano, William A.	46
Mastekaasa, Arne	31	Schlemmer, L.	36
Mathews, W.C.	73	Shibata, Hiroshi	26
McClelland, David C.	32	Singer, J.	68
McLean, A.	72	Sloss, Elizabeth M.	39
McNeil, B.J.	74	Son, L.H.	69
Meenan, R.F.	64	Stark, Oded	47
Meenan, Robert F.	45	Steinwachs, D.M.	66
Mehta, Mahesh P.	42	Stephens, Mary Ann Parris	25
Merbitz, Charles	33	Stewart, Miriam J.	48
Meyers, Allan R.	34	Stones, M.J.	49
Millard, Richard W.	35	Sutherland, S.E.	24
Mitchell, A.	68	Suyama, Yasuo	26
Mitchell, Alba	18	Svardsudd, Kurt	27
Moller, V.	36	Swanson, G. Marie	46
Moos, Rudolf H.	4	Temkin, N.R.	72
Morris, Jeri	33	Tognetti, J.	69
Mossey, Jana M.	37	Tompkins, C.	68
Motenko, Aluma Kopito	38	Torrance, G.W.	63
Mulley, A.G. Jr.	59	Tourigny-Rivard, Marie-France	2
Murphy, Jane M.	53	Tsevat, Joel	50
Mutran, Elizabeth	37	Tugwell, P.	51
Nakazato, Katsuharu	26	Van Tran, Thanh	29
Nelson, E.C.	58	Vertrees, James C.	52
Neufeld, Richard R.	55	Vickery, D.M.	78
Newhouse, Joseph P.	39	Weber, J.	67
OConnell, Paul G.	40	Wedel, Hans	27
O'Donnell, Rita Mahard	41	Weinstein, Milton C.	53
O'Hara, Michael W.	42	Williams, Simon Johnson	54
Okun, Morris A.	57	Williams, N.	68
Orenstein, D.	73	Wright, Ellen J.	42
Oye, Robert K.	11	Wu, A.W.	73
Pace, Wilson D.	43	Yew, Elizabeth	55
Pantell, R.H.	71	Yu, Elena S.H.	56
Patrick, D.L.	60,61	Zautra, Alex J.	57
Pauker, Stephen G.	50	Zhang, Ming-Yuan	56
Pencer, Irwin	2		

acquired immunodeficiency syndrome	73	health promotion	12,62
active life expectancy	44	health services research	76,77
activities of daily living	34,35,37,40,52, 55,57,58,64,67,69,70,72,74	heart disease	24
age factors	29	hemiplegia	40
aged	1,2,3,4,17,24, 26,37,41,45,46,49,57,58,69,74	hip fracture	37
Alameda County Health Survey	17	homeless persons	16
amputation	40	hypertension	22
arthritis	51,57,63,64,73	Index of ADL	55
artificial joints	50	inflammatory bowel diseases	68
back pain	35	instrumental activities of daily living	26,34,46
black persons	24,36	insurance, health	78
breast cancer	46	life stress	57
Breast Cancer Chemotherapy Questionnaire	18	life support care	11
Brief Symptom Inventory	42	measurement properties	18,31,33,51
caregivers.	25,38	medical records	78
CES-D Scale	29,30,37	mental health	16,58
child	21,71	Mental Health Inventory	16,39,53,57
China	56	Mexican-Americans	29
chronic disease	61	Mini-Mental State	56
chronic obstructive pulmonary disease	54	models, theoretical	5,9,19,30,44,47,48,52,66,79
clinical trials	60,63,64,65,68	MOSES Scale	2
cognition	75	National Health Interview Survey	70
cognitive disorders	56	nursing homes	2,4
comparative study	53,69	oral health	67
concept formation	6,20,23,28,32,43,45,48,79	orthopedics	27
cost-utility analysis	50	patient participation	59
cystic fibrosis	73	physician-patient relations	27
decision analysis	63	physician practice patterns	22
dementia	1,25,38	preferences	11,13,14,15,19,28
diagnosis	23	quality of life	8,9,22,31,36,47,51,59, 61,62,63,65,67,68,70,73
Diagnostic Interview Schedule	53	Quality of Well-Being Scale	73
environment	21	rehabilitation	40,55
evaluation studies	61,71,74	residential facilities	4
FROMAJE	55	responsiveness	18
function status	3,4,17,41,42,43,45	review article	54
Functional Assessment Screening Questionnaire	35	SCAG Scale	1
Functional Status Questionnaire	71	SENOTS Program and Battery	49
General Health Perceptions	39	Severity of Illness Index	71
General Health Questionnaire	53	Short, Portable Mental Status Questionnaire	37
General Well-Being Schedule	38	Sickness Impact Profile	72,75
Hassles Scale	25	social behavior	69
head injuries	72	social support	48
Health Assessment Questionnaire	57	South Africa	36
health policy	6,59,60,66	spinal cord injury	34
		surgery	27,42

SUBJECT INDEX

technology assessment	7	visual acuity	3
utility measurement	5,10,13,14,15	Well-Being	21
validity	18	work	8

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. To obtain additional information about purchasing the *Bibliography on Health Indexes* on a regular basis write to the following address:

National Center for Health Statistics
ATTENTION: Scientific and Technical Information Branch
6525 Belcrest Road
Room 1041
Hyattsville, Maryland 20782

(continued from page 1)

- 6 Frankl, David; Oye, Robert K.; Bellamy, Paul E.; Attitudes of Hospitalized Patients Toward Life Support: A Survey of 200 Medical Inpatients; *American Journal of Medicine* 86(6):645-648, 1989
- 7 Fries, James F.; The Compression of Morbidity: Near or Far?; *Milbank Quarterly* 67(2):208-232, 1989
- 7 Froberg, Debra G.; Kane, Robert L.; Methodology for Measuring Health-State Preferences—I: Measurement Strategies; *Journal of Clinical Epidemiology* 42(2):345-354, 1989
- 7 Froberg, Debra G.; Kane, Robert L.; Methodology for Measuring Health-State Preferences—II: Scaling Methods; *Journal of Clinical Epidemiology* 42(5):459-471, 1989
- 8 Froberg, Debra G.; Kane, Robert L.; Methodology for Measuring Health-State Preferences—III: Population and Context Effects; *Journal of Clinical Epidemiology* 42(6):585-592, 1989
- 8 Gelberg, Lillian; Linn, Lawrence S.; Psychological Distress Among Homeless Adults; *Journal of Nervous and Mental Disease* 177(5):291-295, 1989
- 9 Guralnik, Jack M.; Kaplan, George A.; Predictors of Healthy Aging: Prospective Evidence From the Alameda County Study; *American Journal of Public Health* 79(6):703-708, 1989
- 9 Guyatt, Gordon H.; Deyo, Richard A.; Charlson, Mary; Levine, Mark N.; Mitchell, Alba; Responsiveness and Validity in Health Status Measurement: A Clarification; *Journal of Clinical Epidemiology* 42(5):403-408, 1989
- 9 Harrington, Joseph E. Jr.; If *Homo Economicus* Could Choose His Own Utility Function, Would He Want One with a Conscience? Comment; *American Economic Review* 79(3):588-593, 1989

- 10 Hirschman, Albert O.; The Quality of Life: Having Opinions—One of the Elements of Well-Being?; *American Economic Review* 79(2):75–79, 1989
- 10 Homel, Ross; Burns, Ailsa; Environmental Quality and the Well-being of Children; *Social Indicators Research* 21(2):133–158, 1989
- 11 Hume, Anne L.; Applying Quality of Life Data in Practice: Considerations for Antihypertensive Therapy; *Journal of Family Practice* 28(4):403–411, 1989
- 11 Hunt, Linda M.; Jordan, Brigitte; Irwin, Susan; Views of What's Wrong: Diagnosis and Patients' Concepts of Illness; *Social Science and Medicine* 28(9):945–956, 1989
- 11 Keil, J.E.; Gazes, P.C.; Sutherland, S.E.; Rust, P.F.; Branch, L.G.; et al.; Predictors of Physical Disability in Elderly Blacks and Whites of the Charleston Heart Study; *Journal Clinical of Epidemiology* 42(6):521–529, 1989
- 12 Kinney, Jennifer M.; Stephens, Mary Ann Parris; Caregiving Hassles Scale: Assessing the Daily Hassles of Caring for a Family Member With Dementia; *Gerontologist* 29(3):328–332, 1989
- 12 Koyano, Wataru; Shibata, Hiroshi; Nakazato, Katsuharu; Haga, Hiroshi; Suyama, Yasuo; et al.; Mortality in Relation to Instrumental Activities of Daily Living: One-Year Follow-up in a Japanese Urban Community; *Journal of Gerontology* 44(3):S107–S109, 1989
- 12 Larsson, Ullabeth Satterlund; Svardsudd, Kurt; Wedel, Hans; Saljo, Roger; Patient Involvement in Decision-Making in Surgical and Orthopaedic Practice: The Project Perioperative Risk; *Social Science and Medicine* 28(8):829–835, 1989
- 13 Levy, Haim; Two-Moment Decision Models and Expected Utility Maximization: Comment; *American Economic Review* 79(3):597–600, 1989
- 13 Liang, Jersey; Tran, Thanh Van; Krause, Neal; Markides, Kyriakos S.; Generational Differences in the Structure of the CES–D Scale in Mexican Americans; *Journal of Gerontology* 44(3):S110–S120, 1989
- 13 Lin, Nan; Ensel, Walter M.; Life Stress and Health: Stressors and Resources; *American Sociological Review* 54:382–399, 1989
- 14 Mastekaasa, Arne; Kaasa, Stein; Measurement Error and Research Design: A Note on the Utility of Panel Data in Quality of Life Research; *Social Indicators Research* 21(3):315–335, 1989
- 14 McClelland, David C.; Motivational Factors in Health and Disease; *American Psychologist* 44(4):675–683, 1989
- 14 Merbitz, Charles; Morris, Jeri; Grip, Jeffrey C.; Ordinal Scales and Foundations of Misinference; *Archives of Physical Medicine and Rehabilitation* 70(4):308–312, 1989
- 15 Meyers, Allan R.; Branch, Laurence G.; Cupples, L. Adrienne; Lederman, Ruth I.; Feltin, Marie; Predictors of Medical Care Utilization by Independently Living Adults With Spinal Cord Injuries; *Archives of Physical Medicine and Rehabilitation* 70(6):471–476, 1989
- 15 Millard, Richard W.; The Functional Assessment Screening Questionnaire: Application for Evaluating Pain-Related Disability; *Archives of Physical Medicine and Rehabilitation* 70(4):303–307, 1989

- 16 Moller, V.; Schlemmer, L.; South African Quality of Life: A Research Note; *Social Indicators Research* 21(3):279-291, 1989
- 16 Mossey, Jana M.; Mutran, Elizabeth; Knott, Kathryn; Craik, Rebecca; Determinants of Recovery 12 Months After Hip Fracture: The Importance of Psychosocial Factors; *American Journal of Public Health* 79(3):279-286, 1989
- 17 Motenko, Aluma Kopito; The Frustrations, Gratifications, and Well-Being of Dementia Caregivers; *Gerontologist* 29(2):166-172, 1989
- 17 Newhouse, Joseph P.; Manning, Willard G.; Keeler, Emmett B.; Sloss, Elizabeth M.; Adjusting Capitation Rates Using Objective Health Measures and Prior Utilization; *Health Care Financing Review* 10(3):41-54, 1989
- 17 OConnell, Paul G.; Gnatz, Steven; Hemiplegia and Amputation: Rehabilitation in the Dual Disability; *Archives of Physical Medicine and Rehabilitation* 70(6):451-454, 1989
- 18 O'Donnell, Rita Mahard; Functional Disability Among the Puerto Rican Elderly; *Journal of Aging and Health* 1(2):244-264
- 18 O'Hara, Michael W.; Ghoneim, Mohamed M.; Hinrichs, James V.; Mehta, Mahesh P.; Wright, Ellen J.; Psychological Consequences of Surgery; *Psychosomatic Medicine* 51(3):356-370, 1989
- 18 Pace, Wilson D.; Geriatric Assessment in the Office Setting; *Geriatrics* 44(6):29-35, 1989
- 19 Rogers, Andrei; Rogers, Richard G.; Branch, Laurence G.; A Multistate Analysis of Active Life Expectancy; *Public Health Reports* 104(3):222-225, 1989
- 19 Rubenstein, Lisa V.; Calkins, David R.; Greenfield, Sheldon; Jette, Alan M.; Meenan, Robert F.; et al.; Health Status Assessment for Elderly Patients: Report of the Society of General Internal Medicine Task Force on Health Assessment; *Journal of the American Geriatrics Society* 37(6):562-569, 1988
- 19 Satariano, William A.; Ragheb, Nawal E.; Buck, Karen A.; Swanson, G. Marie; Branch, Laurence G.; Aging and Breast Cancer: A Case-Control Comparison of Instrumental Functioning; *Journal of Aging and Health* 1(2):209-233, 1989
- 20 Stark, Oded; Altruism and the Quality of Life; *American Economic Review* 79(2):86-90, 1989
- 20 Stewart, Miriam J.; Social Support: Diverse Theoretical Perspectives; *Social Science and Medicine* 28(12):1275-1282, 1989
- 21 Stones, M.J.; Kozma, Albert; Multidimensional Assessment of the Elderly via a Microcomputer: The SENOTS Program and Battery; *Psychology and Aging* 4(1):113-118, 1989
- 21 Tsevat, Joel; Durand-Zaleski, Isabelle; Pauker, Stephen G.; Cost-Effectiveness of Antibiotic Prophylaxis for Dental Procedures in Patients With Artificial Joints; *American Journal of Public Health* 79(6):739-743, 1989
- 22 Tugwell, P.; Bombardier, C.; Bensen, W.; Grace, E.; Bennett, K.; et al.; Current Quality-of-Life Research Challenges in Arthritis Relevant to the Issue of Clinical Significance; Unpublished, Hamilton, Ontario, Canada: McMaster University

- 22 Vertrees, James C.; Manton, Kenneth G.; Adler, Gerald S.; Cost Effectiveness of Home and Community-Based Care; *Health Care Financing Review* 10(4):65-78, 1989
- 22 Weinstein, Milton C.; Berwick, Donald M.; Goldman, Paula A.; Murphy, Jane M.; Barsky, Arthur J.; A Comparison of Three Psychiatric Screening Tests Using Receiver Operating Characteristic (ROC) Analysis; *Medical Care* 27(6):593-606, 1989
- 23 Williams, Simon Johnson; Chronic Respiratory Illness and Disability: A Critical Review of the Psychosocial Literature; *Social Science and Medicine* 28(8):791-803, 1989
- 23 Yew, Elizabeth; Kropsky, Benjamin A.; Neufeld, Richard R.; Libow, Leslie S.; The Clinical Utility of a Comprehensive Periodic Assessment Form for the Geriatric Rehabilitation Patient; *Gerontologist* 29(2):263-267, 1989
- 23 Yu, Elena S.H.; Liu, William T.; Levy, Paul; Zhang, Ming-Yuan; Katzman, Robert; et al.; Cognitive Impairment Among Elderly Adults in Shanghai, China; *Journal of Gerontology* 44(3):S97-S106, 1989
- 24 Zautra, Alex J.; Okun, Morris A.; Robinson, Sharon E.; Lee, Douglas; Roth, Sanford H.; Life Stress and Lymphocyte Alterations Among Patients with Rheumatoid Arthritis; *Health Psychology* 8(1):1-14, 1989
- 25 SOURCES of INFORMATION
- 27 SELECTIONS from NLM
- 37 AUTHOR INDEX
- 39 SUBJECT INDEX
- 41 CLEARINGHOUSE—SCOPE and SERVICES

**DEPARTMENT OF
HEALTH & HUMAN SERVICES**

Public Health Service
Centers for Disease Control
National Center for Health Statistics
6525 Belcrest Road
Hyattsville, Maryland 20782

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE, \$300

DHHS Publication No. (PHS) 91-1225

BULK RATE
POSTAGE & FEES PAID
PHS/NCHS
PERMIT NO. G-281