



LIBRARY AND INFORMATION SERVICE

CURRENT AWARENESS BULLETIN

JULY-AUGUST 2009

ACCESS TO CARE.....	3
CHRONIC ILLNESS	7
COMMISSIONING.....	16
COMORBIDITY.....	16
GOVERNANCE.....	20
HEALTH ECONOMICS	22
HEALTH INEQUALITIES	25
HEALTH POLICY.....	27
INFORMATION AND COMMUNICATIONS TECHNOLOGY.....	28
MEDICINES MANAGEMENT	29
MENTAL HEALTH.....	33
PATIENT AND PUBLIC INVOLVEMENT	43
PRIMARY/SECONDARY CARE INTERFACE.....	48
QUALITY	50
RESEARCH AND DEVELOPMENT	55
SELF CARE	61
SERVICE ORGANIZATION AND DELIVERY	65
SOCIAL CAPITAL	66
WORKFORCE	67

Where possible, a digital object identifier (doi) and a PubMed identifier have been provided for each article. Please inform the Library staff if any of these do not work, so the matter can be investigated. These citations have been derived from PubMed.

ACCESS TO CARE

Croker, J.E., & Campbell, J.L. (2009). Satisfaction with access to healthcare: qualitative study of rural patients and practitioners. *Primary Health Care Research & Development*, 10:309-319

<http://dx.doi.org/10.1017/S146342360999015>

Aim To gain insight into factors affecting patient and practitioner satisfaction with access to healthcare in a remote rural island community. **Background** General practice based primary care is the focus of health service delivery in rural areas of the UK. Individuals from rural populations have reported inequalities in access to healthcare. User satisfaction with service performance is recognised as an important outcome of healthcare. Further investigation into factors underpinning patient and practitioner satisfaction with access to rural healthcare is required. **Design of Study** Qualitative interviews with patients and primary healthcare practitioners. **Setting** Isles of Scilly, Cornwall, UK. **Methods** A topic guide was developed following review of the literature. In-depth, semi-structured interviews with a purposive sample of 23 participants were conducted with individuals from all inhabited islands. Detailed field notes were kept, and interview content was partially transcribed and analysed thematically. **Findings** Principal themes identified were common to patient and practitioner participants. These were: concerns expressed regarding the equitable provision of services; obstacles to using health services; and the outlook of patients and professionals, including expectations, choice, patient-practitioner relationships and community cohesiveness. **Emerging themes** gave insight into a range of factors affecting satisfaction with access to healthcare. **Conclusion** Despite numerous policy initiatives aimed at reducing inequities in health service provision, problems with access and uptake of health services persist amongst individuals from remote rural populations. If implemented, recent National Health Service proposals may address some of the challenges identified by participants. Service developments need to take account of local priorities, expectations, geography and demography to achieve favourable outcomes

Howard, M., Agarwal, G., & Hilts, L. (2009). Patient satisfaction with access in two interprofessional academic family medicine clinics. *Family Practice* Epub ahead of print 10/07/2009

<http://dx.doi.org/10.1093/fampra/cmp049>

<http://pmid.us/19592414>

Background: Satisfaction with access to primary care is one component of overall patient satisfaction. The objectives of this paper were to describe patient satisfaction with access in interprofessional family practices and to examine predictors of being less than satisfied with access. **Methods:** A survey was mailed to 770 randomly selected patients in two academic interprofessional family practices in Hamilton, Canada. Most items were positively worded statements on a five-point scale from strongly agree to strongly

disagree. Outcomes were the proportion of respondents agreeing with statements regarding access. For items where $\geq 25\%$ of respondents did not agree, we examined socio-demographic predictors of disagreement using multiple variable logistic regression. Results: The response rate was 49.9% (384/770). One-quarter or more of respondents did not agree that they received an explanation if the appointment was delayed at the office, obtain urgent appointments, obtain prescription refills without a visit or that wait times at the office were reasonable. Predictors of not agreeing included younger age, being married or single, more educated, employed and of non-white ethnicity. Less than 10 minutes was the most satisfactory wait time for the appointment to begin; however, the most common wait time reported was 11-20 minutes. One-quarter of respondents had visited the weekend/holiday clinic in the past 12 months; however, use was not associated with perceived ability to obtain an appointment in 1-2 days. Conclusions: While satisfaction was generally high, some aspects of access could be improved by changes in practice organization or patient education regarding expectations

Huibers,L., et al (2009). Out-of-hours care in western countries: assessment of different organizational models. *BMC Health Services Research* 9 :105.

<http://dx.doi.org/10.1186/1472-6963-9-105>

<http://www.biomedcentral.com/1472-6963/9/105>

<http://pmid.us/19549325>

Background: Internationally, different organizational models are used for providing out-of-hours care. The aim of this study was to assess prevailing models in order to identify their potential strengths and weaknesses. Methods: An international web-based survey was done in 2007 in a sample of purposefully selected key informants from 25 western countries. The questions concerned prevailing organizational models for out-of-hours care, the most dominant model in each country, perceived weaknesses, and national plans for changes in out-of-hours care. Results: A total of 71 key informants from 25 countries provided answers. In most countries several different models existed alongside each other. The Accident and Emergency department was the organizational model most frequently used. Perceived weaknesses of this model concerned the coordination and continuity of care, its efficiency and accessibility. In about a third of the countries, the rota group was the most dominant organizational model for out-of-hours care. A perceived weakness of this model was lowered job satisfaction of physicians. The GP cooperative existed in a majority of the participating countries; no weaknesses were mentioned with respect to this model. Most of the countries had plans to change the out-of-hours care, mainly toward large scale organizations. Conclusion: GP cooperatives combine size of scale advantages with organizational features of strong primary care, such as high accessibility, continuity and coordination of care. While specific patients require other organizational models, the co-existence of different organizational models for out-of-hours care in a country may be less efficient for health systems

MacFarlane, A., et al & (2009). Arranging and negotiating the use of informal interpreters in general practice consultations: Experiences of refugees and asylum seekers in the west of Ireland. *Social Science & Medicine*, 69(2), 210-214.

<http://dx.doi.org/10.1016/j.socscimed.2009.04.022>

<http://pmid.us/19535192>

This paper focuses on the work involved for service users in arranging and negotiating the use of informal interpreters from their social networks for general practice consultations. The data are drawn from a participatory learning and action research study, carried out in the west of Ireland. Qualitative data were gathered using a peer researcher model from a 'hard to reach' community of Serbo-Croat and Russian refugees and asylum seekers (n=26). The findings elucidate that there is a tension for service users between the experienced benefits of having a trusted friend/family member present to act as their interpreter and the burden of work and responsibility to manage the language barrier. Participants emphasize that, for them, the use of informal interpreters can be inadequate and problematic and can leave them worried, frustrated and with experiences of error and misdiagnosis. Overall, they state a clear preference for the use of professional, trained interpreters in general practice consultations which is currently unavailable to them in routine Irish general practice consultations

McGrail, M., & Humphreys, J. (2009). The index of rural access: an innovative integrated approach for measuring primary care access. *BMC Health Services Research*, 9(1), 124.

<http://dx.doi.org/10.1186/1472-6963-9-124>

<http://www.biomedcentral.com/1472-6963/9/124>

<http://pmid.us/19624859>

Background: The problem of access to health care is of growing concern for rural and remote populations. Many Australian rural health funding programs currently use simplistic rurality or remoteness classifications as proxy measures of access. This paper outlines the development of an alternative method for the measurement of access to primary care, based on combining the three key access elements of spatial accessibility (availability and proximity), population health needs and mobility. Methods: The recently developed two-step floating catchment area (2SFCA) method provides a basis for measuring primary care access in rural populations. In this paper, a number of improvements are added to the 2SFCA method in order to overcome limitations associated with its current restriction to a single catchment size and the omission of any distance decay function. Additionally, small-area measures for the two additional elements, health needs and mobility are developed. By utilising this improved 2SFCA method, the three access elements are integrated into a single measure of access. This index has been developed within the state of Victoria, Australia. Results: The resultant index, the Index of Rural Access, provides a more sensitive and appropriate measure of

access compared to existing classifications which currently underpin policy measures designed to overcome problems of limited access to health services. The most powerful aspect of this new index is its ability to identify access differences within rural populations at a much finer geographical scale. This index highlights that many rural areas of Victoria have been incorrectly classified by existing measures as homogenous in regards to their access. Conclusion: The Index of Rural Access provides the first truly integrated index of access to primary care. This new index can be used to better target the distribution of limited government health care funding allocated to address problems of poor access to primary health care services in rural areas

Nazroo,J., et al (2009). Ethnic inequalities in access to and outcomes of healthcare: Analysis of the Health Survey for England. *Journal of Epidemiology and Community Health*. Epub ahead of print 20/7/2009

<http://dx.doi.org/10.1136/jech.2009.089409>

<http://pmid.us/19622520>

Background: Ethnic/racial inequalities in access to and quality of healthcare have been repeatedly documented in the US. Although there is some evidence of inequalities in England, research is not so extensive. We examine ethnic inequalities in use of primary and secondary health services, and in outcomes of care, in England. Methods: We analyse four waves of the Health Survey for England, a representative population survey with ethnic minority oversamples. Outcome measures include use of primary (GP and dental) and secondary (out-patient, day-care and in-patient) healthcare services and clinical outcomes of care (controlled, uncontrolled and undiagnosed) for three conditions - hypertension, raised cholesterol, and diabetes. Results: Ethnic minority respondents were not less likely to use GP services. For example, the adjusted odds ratios for Indian, Pakistani and Bangladeshi versus white respondents were 1.29 (95% Confidence Intervals 1.07-1.54), 1.32 (1.10-1.58) and 1.35 (1.10-1.65) respectively. Similarly, there were no ethnic inequalities for the clinical outcomes of care for hypertension and raised cholesterol, and, on the whole, no inequalities in outcomes of care for diabetes. There were ethnic inequalities in access to hospital services, and marked inequalities in use of dental care. Conclusion: Ethnic inequalities in access to healthcare and the outcomes of care for three conditions (hypertension, raised cholesterol and diabetes), for which treatment is largely provided in primary care, appear to be minimal in England. While inequalities may exist for other conditions and other health care settings, particularly internationally, the implication is that ethnic inequalities in healthcare are minimal within NHS primary care

CHRONIC ILLNESS

Bodenheimer, T., & Handley, M.A. (2009). Goal-setting for behavior change in primary care: An exploration and status report. *Patient Education and Counseling*, 76(2), 174-180.

<http://dx.doi.org/10.1016/j.pec.2009.06.001>

<http://pmid.us/19560895>

Objective This paper explores the behavior change method of goal-setting and reviews the literature on goal-setting in primary care for patients with chronic conditions. **Methods** A literature search was conducted resulting in eight articles meeting the criteria of goal-setting interventions in primary care for adults or adolescents with chronic conditions. **Results** Hypotheses are advanced that goal-setting is generally conducted by collaboratively working with patients to set short-term and specific goals, with follow-up to provide feedback to patients. The articles reviewed generally confirmed these hypotheses. This review did not focus on clinical outcomes, but on the processes of engaging patients in goal-setting discussions. **Conclusion** Evidence that goal-setting is superior to other behavior change methods has not been shown. Since goal-setting is being utilized as a behavior change technique in many primary care sites, primary care practices can benefit from information on how best to implement this innovation. **Practice Implications** Generally, clinicians are minimally involved in goal-setting discussions with their patients. Engaging patients in goal-setting can be done with interactive computer programs and non-clinical members of the primary care team

Copeland, L. et al (2009). Patterns of primary care and mortality among patients with schizophrenia or diabetes: a cluster analysis approach to the retrospective study of healthcare utilization. *BMC Health Services Research*, 9(1), 127.

<http://dx.doi.org/10.1186/1472-6963-9-127>

<http://www.biomedcentral.com/1472-6963/9/127>

<http://pmid.us/19630997>

Background: Patients with schizophrenia have difficulty managing their medical healthcare needs, possibly resulting in delayed treatment and poor outcomes. We analyzed whether patients reduced primary care use over time, differentially by diagnosis

with schizophrenia, diabetes, or both schizophrenia and diabetes. We also assessed whether such patterns of primary care use were a significant predictor of mortality over a 4-year period. Methods: The Veterans Healthcare Administration (VA) is the largest integrated healthcare system in the United States. Administrative extracts of the VA's all-electronic medical records were studied. Patients over age 50 and diagnosed with schizophrenia in 2002 were age-matched 1:4 to diabetes patients. All patients were followed through 2005. Cluster analysis explored trajectories of primary care use. Proportional hazards regression modelled the impact of these primary care utilization trajectories on survival, controlling for demographic and clinical covariates. Results: Patients comprised three diagnostic groups: diabetes only (n = 188,332), schizophrenia only (n = 40,109), and schizophrenia with diabetes (Scz-DM, n = 13,025). Cluster analysis revealed four distinct trajectories of primary care use: consistent over time, increasing over time, high and decreasing, low and decreasing. Patients with schizophrenia only were likely to have low-decreasing use (73% schizophrenia-only vs 54% Scz-DM vs 52% diabetes). Increasing use was least common among schizophrenia patients (4% vs 8% Scz-DM vs 7% diabetes) and was associated with improved survival. Low-decreasing primary care, compared to consistent use, was associated with shorter survival controlling for demographics and case-mix. The observational study was limited by reliance on administrative data. Conclusion: Regular primary care and high levels of primary care were associated with better survival for patients with chronic illness, whether psychiatric or medical. For schizophrenia patients, with or without comorbid diabetes, primary care offers a survival benefit, suggesting that innovations in treatment retention targeting at-risk groups can offer significant promise of improving outcomes

Echouffo-Tcheugui, J.B. et al (2009). The ADDITION-Cambridge trial protocol: a cluster -- randomised controlled trial of screening for type 2 diabetes and intensive treatment for screen-detected patients. *BMC Public Health*, 9 136.

<http://dx.doi.org/10.1186/1471-2458-9-136>

<http://www.biomedcentral.com/1471-2458/9/136>

<http://pmid.us/19435491>

Background: The increasing prevalence of type 2 diabetes poses a major public health challenge. Population-based screening and early treatment for type 2 diabetes could reduce this growing burden. However, the benefits of such a strategy remain uncertain. Methods and design: The ADDITION-Cambridge study aims to evaluate the effectiveness and cost-effectiveness of (i) a stepwise screening strategy for type 2 diabetes; and (ii) intensive multifactorial treatment for people with screen-detected diabetes in primary care. 63 practices in the East Anglia region participated. Three

undertook the pilot study, 33 were allocated to three groups: no screening (control), screening followed by intensive treatment (IT) and screening plus routine care (RC) in an unbalanced (1:3:3) randomisation. The remaining 27 practices were randomly allocated to IT and RC. A risk score incorporating routine practice data was used to identify people aged 40-69 years at high-risk of undiagnosed diabetes. In the screening practices, high-risk individuals were invited to take part in a stepwise screening programme. In the IT group, diabetes treatment is optimised through guidelines, target-led multifactorial treatment, audit, feedback, and academic detailing for practice teams, alongside provision of educational materials for newly diagnosed participants. Primary endpoints are modelled cardiovascular risk at one year, and cardiovascular mortality and morbidity at five years after diagnosis of diabetes. Secondary endpoints include all-cause mortality, development of renal and visual impairment, peripheral neuropathy, health service costs, self-reported quality of life, functional status and health utility. Impact of the screening programme at the population level is also assessed through measures of mortality, cardiovascular morbidity, health status and health service use among high-risk individuals. Discussion: ADDITION-Cambridge is conducted in a defined high-risk group accessible through primary care. It addresses the feasibility of population-based screening for diabetes, as well as the benefits and costs of screening and intensive multifactorial treatment early in the disease trajectory. The intensive treatment algorithm is based on evidence from studies including individuals with clinically diagnosed diabetes and the education materials are informed by psychological theory. ADDITION-Cambridge will provide timely evidence concerning the benefits of early intensive treatment and will inform policy decisions concerning screening for type 2 diabetes.

Goyder,E., Carlisle,J., Lawton,J., & Peters,J. (2009). Informed choice and diabetes screening in primary care: Qualitative study of patient and professional views in deprived areas of England. *Primary Care Diabetes*. Online 22 May 2009.

<http://dx.doi.org/10.1016/j.pcd.2009.04.001>

<http://pmid.us/19464976>

Aims: To examine perceived need for, and provision of, information prior to participation in a diabetes screening programme in English general practices. Methods: Case studies using qualitative semi-structured interviews with patients and practitioners in five participating practices. Results: Participating patients generally demonstrated a lack of understanding of issues in relation to the benefits and disadvantages of diabetes screening or the implications of screening test results. Posted invitation letters provided written information but did not necessarily ensure that patients were better informed than those invited by telephone or opportunistically when attending the practice for another reason. Not all patients interviewed wanted the extent of information that would be required to enable them to give fully informed consent to screening. Conclusions: The ways in which information is provided to patients requires careful consideration so that a patient has sufficient understanding to make a decision about undergoing a screening test and

understands the implications of test results. There is a potential conflict between the ideal of fully informed choice and patient expectations that they can depend on professionals to make the appropriate decision on their behalf

Guldberg, T.L., et al (2009). The effect of feedback to general practitioners on quality of care for people with type 2 diabetes. A systematic review of the literature. *BMC Family Practice* 10 30.

<http://dx.doi.org/10.1186/1471-2296-10-30>

<http://www.biomedcentral.com/1471-2296/10/30>

<http://pmid.us/19419548>

Background: There have been numerous efforts to improve and assure the quality of treatment and follow-up of people with Type 2 diabetes (PT2D) in general practice. Facilitated by the increasing usability and validity of guidelines, indicators and databases, feedback on diabetes care is a promising tool in this aspect. Our goal was to assess the effect of feedback to general practitioners (GPs) on the quality of care for PT2D based on the available literature. Methods: Systematic review searches were conducted using October 2008 updates of Medline (Pubmed), Cochrane library and Embase databases. Additional searches in reference lists and related articles were conducted. Papers were included if published in English, performed as randomized controlled trials, studying diabetes, having general practice as setting and using feedback to GPs on diabetes care. The papers were assessed according to predefined criteria. Results: Ten studies complied with the inclusion criteria. Feedback improved the care for PT2D, particularly process outcomes such as foot exams, eye exams and HbA1c measurements. Clinical outcomes like lowering of blood pressure, HbA1c and cholesterol levels were seen in few studies. Many process and outcome measures did not improve, while none deteriorated. Meta analysis was unfeasible due to heterogeneity of the studies included. Two studies used electronic feedback. Conclusion: Based on this review, feedback seems a promising tool for quality improvement in diabetes care, but more research is needed, especially of electronic feedback

Lawton, J., Rankin, D., Peel, E., & Douglas, M. (2009). Patients' perceptions and experiences of transitions in diabetes care: a longitudinal qualitative study. *Health Expectations* 12(2), 138-148.

<http://dx.doi.org/10.1111/j.1369-7625.2009.00537.x>

<http://pmid.us/19309488>

Objective: To examine patients' perceptions and experiences over time of the devolvement of diabetes care/reviews from secondary to primary health-care settings. Design: Repeat in-depth interviews with 20 patients over 4 years. Participants And setting: Twenty type 2 diabetes patients recruited from primary- and secondary-care

settings across Lothian, Scotland. Results: Patients' views about their current diabetes care were informed by their previous service contact. The devolvement of diabetes care/reviews to general practice was presented as a 'mixed blessing'. Patients gained reassurance from their perception that receiving practice-based care/reviews signified that their diabetes was well-controlled. However, they also expressed resentment that, by achieving good control, they received what they saw as inferior care and/or less-frequent reviews to others with poorer control. While patients tended to regard GPs as having adequate expertise to conduct their practice-based reviews, they were more ambivalent about nurses taking on this role. Opportunities to receive holistic care in general practice were not always realized due to patients seeing health-care professionals for diabetes management to whom they would not normally present for other health issues. Conclusions: It is important to educate patients about their care pathways, and to reassure them that frequency of reviews depends more on clinical need than location of care and that similar care guidelines are followed in hospital clinics and general practice. A patients' history of service contact may need to be taken into account in future studies of service satisfaction

Patterson,C.C., et al . (2009). Incidence trends for childhood type 1 diabetes in Europe during 1989-2003 and predicted new cases 2005-20: a multicentre prospective registration study. *Lancet*, 373(9680), 2027-2033

[http://dx.doi.org/10.1016/S0140-6736\(09\)60568-7](http://dx.doi.org/10.1016/S0140-6736(09)60568-7)

<http://pmid.us/19481249>

Background: The incidence of type 1 diabetes in children younger than 15 years is increasing. Prediction of future incidence of this disease will enable adequate fund allocation for delivery of care to be planned. We aimed to establish 15-year incidence trends for childhood type 1 diabetes in European centres, and thereby predict the future burden of childhood diabetes in Europe. Methods: 20 population-based EURODIAB registers in 17 countries registered 29 311 new cases of type 1 diabetes, diagnosed in children before their 15th birthday during a 15-year period, 1989-2003. Age-specific log linear rates of increase were estimated in five geographical regions, and used in conjunction with published incidence rates and population projections to predict numbers of new cases throughout Europe in 2005, 2010, 2015, and 2020. Findings: Ascertainment was better than 90% in most registers. All but two registers showed significant yearly increases in incidence, ranging from 0.6% to 9.3%. The overall annual increase was 3.9% (95% CI 3.6-4.2), and the increases in the age groups 0-4 years, 5-9 years, and 10-14 years were 5.4% (4.8-6.1), 4.3% (3.8-4.8), and 2.9% (2.5-3.3), respectively. The number of new cases in Europe in 2005 is estimated as 15 000, divided between the 0-4 year, 5-9 year, and 10-14 year age-groups in the ratio 24%, 35%, and 41%, respectively. In 2020, the predicted number of new cases is 24 400, with a doubling in numbers in children younger than 5 years and a more even distribution across age-groups than at present (29%, 37%, and 34%, respectively). Prevalence under age 15 years is predicted to rise from 94 000 in 2005, to 160 000 in 2020. Interpretation: If present trends continue, doubling of new cases of type 1 diabetes in European children younger than 5 years is predicted between 2005 and 2020, and prevalent cases younger than 15 years will rise by

70%. Adequate health-care resources to meet these children's needs should be made available. Funding: European Community Concerted Action Program

Peters-Klimm,F et al (2009). Physicians' view of primary care-based case management for patients with heart failure: a qualitative study. *International Journal of Quality in Health Care*. Epub ahead of print 14th August 2009

<http://dx.doi.org/10.1093/intqhc/mzp032>

<http://pmid.us/19684033>

Background: As part of a trial aiming to improve care for patients with chronic (systolic) heart failure, a standardized, multifaceted case management approach was evaluated in German general practices. It consisted of regular telephone monitoring, home visits, health counselling, diagnostic screening and booklets for patients. Practice-based doctors' assistants (equivalent to a nursing role) adopted these new tasks and reported regularly to the employing general practitioner (GP). Objective: To explore GPs' perceptions of case management, subsequent changes in relationships within the practice team and the potential future role. Method: Twenty-four GPs participated in five moderated, semi-structured, audio-taped focus groups. Full transcription and thematic content analysis was undertaken. Results: GPs rated all elements and instruments of case management conducted by doctors' assistants feasible, except for the geriatric assessment as patients had not been at risk. GPs perceived difficulties in their own role in delivering health behaviour counselling. Relationships between doctors' assistants and patients and between GPs and patients or doctors' assistants remained stable or improved. All GPs perceived a variety of role changes in doctors' assistants including more in-depth medical knowledge and higher responsibilities yielding more recognition by patients and GPs. Some GPs suggested transferring the case management programme to other chronic conditions and that it should form part of a further education curriculum for doctors' assistants. Conclusion: This primary care-based case management model characterized by the orchestrated delegation of tasks to doctors' assistants offers a promising strategy of enhanced chronic illness care, but it needs further adaptation and evaluation

Peters-Klimm,F., et al (2009). Primary care-based multifaceted, interdisciplinary medical educational intervention for patients with systolic heart failure: lessons learned from a cluster randomised controlled trial. *Trials*, 10(1), 68. 13th August 2009

<http://dx.doi.org/10.1186/1745-6215-10-68>

<http://www.trialsjournal.com/content/10/1/68>

<http://pmid.us/19678944>

Background: Chronic (systolic) heart failure (CHF) is a common and disabling condition. Adherence to evidence-based guidelines in primary care has been shown to improve health outcomes. The aim was to explore the impact of a multidisciplinary educational intervention for general practitioners (GPs) (Train the trainer = TTT) on patient and

performance outcomes. **Methods:** This paper presents the key findings from the trial and discusses the lessons learned during the implementation of the TTT trial. Primary care practices were randomly assigned to the TTT intervention or to the control group. 37 GPs (18 TTT, 19 control) were randomised and 168 patients diagnosed with ascertained CHF (91 TTT, 77 control) were enrolled. GPs in the intervention group attended four meetings addressing clinical practice guidelines and pharmacotherapy feedback. The primary outcome was patient self-reported quality of life at seven months, using the SF-36 Physical Functioning scale. Secondary outcomes included other SF-36 scales, the Kansas City Cardiomyopathy Questionnaire (KCCQ), total mortality, heart failure hospital admissions, prescribing, depressive disorders (PHQ-9), behavioural change (European Heart Failure Self-Care Behaviour Scale), patient-perceived quality of care (EUROPEP) and improvement of heart failure using NT-proBNP-levels. Because recruitment targets were not achieved an exploratory analysis was conducted. **Results:** There was high baseline achievement in both groups for many outcomes. At seven months, there were no significant mean difference between groups for the primary outcome measure (-3.3, 95%CI -9.7 to 3.1, p=0.30). The only difference in secondary outcomes related to the prescribing of aldosterone antagonists by GPs in the intervention group, with significant between group differences at follow-up (42 vs. 24%, adjusted OR=4.0, 95%CI 1.2-13; p=0.02). **Conclusions:** The intervention did not change the primary outcome or most secondary outcomes. Recruitment targets were not achieved and the under-recruitment of practices and patients alongside a selection bias of participating GPs, prohibit definite conclusions, but the CI indicates a non-effectiveness of the intervention in this sample. We describe the lessons learned from conducting the trial for the future planning and conduct of confirmatory trials in primary care.

Russell,G.M., et al (2009). Managing chronic disease in Ontario primary care: the impact of organizational factors. *Annals of Family Medicine*, 7(4), 309-318.

<http://dx.doi.org/10.1370/afm.982>

<http://pmid.us/19597168>

Purpose: New approaches to chronic disease management emphasize the need to improve the delivery of primary care services to meet the needs of chronically ill patients. This study (1) assessed whether chronic disease management differed among 4 models of primary health care delivery and (2) identified which practice organizational factors were independently associated with high-quality care. **MethodS:** We undertook a cross-sectional survey with nested qualitative case studies (2 practices per model) in 137 randomly selected primary care practices from 4 delivery models in Ontario Canada: fee for service, capitation, blended payment, and community health centers (CHCs). Practice and clinician surveys were based on the Primary Care Assessment Tool. A chart audit assessed evidence-based care delivery for patients with diabetes, congestive heart failure, and coronary artery disease. Intermediate outcomes were calculated for patients with diabetes and hypertension. Multiple linear regression identified those organizational factors independently associated with chronic disease management. **Results:** Chronic disease management was superior in CHCs. Clinicians in CHCs found it easier than those

in the other models to promote high-quality care through longer consultations and interprofessional collaboration. Across the whole sample and independent of model, high-quality chronic disease management was associated with the presence of a nurse-practitioner. It was also associated with lower patient-family physician ratios and when practices had 4 or fewer full-time-equivalent family physicians. Conclusions: The study adds to the literature supporting the value of nurse-practitioners within primary care teams and validates the contributions of Ontario's CHCs. Our observation that quality of care decreased in larger, busier practices suggests that moves toward larger practices and greater patient-physician ratios may have unanticipated negative effects on processes of care quality

Sells,D., et al (2009). Cascading crises, resilience and social support within the onset and development of multiple chronic conditions. *Chronic Illness*, 5(2), 92-102.

<http://dx.doi.org/10.1177/1742395309104166>

<http://pmid.us/19474232>

Objective: To describe and better understand adults' responses to the onset, accrual and influence of multiple chronic conditions and to social support in adapting to consequent difficulties. Methods: Qualitative study of 33 adults with multiple chronic illnesses randomly sampled from an urban primary care clinic. Semi-structured interviews targeted retrospective accounts of illness onset, consequent loss, as well as current accounts of social support and adaptation. All interviews were audio-recorded, professionally transcribed and analysed according to established phenomenological procedures. Results: Participants' responses revealed illness onset as a virtual cascade of medical, emotional and social hardships, leading to loss and subsequent adaptation through personal resilience and particularly, available social support. Participants also described patterns of adaptation punctuated by the felt need and rewards of providing care to others. Discussion: The experience of multiple chronic illnesses has a distinct pattern of development and consequence, involving challenges to personal identity and the benefits of social support from and to others. Our results suggest that programmes addressing the needs of persons with multiple chronic conditions might tailor interventions in ways that maximally address their unique challenges

Vrijhoef,H.J. et al (2009). Quality of integrated chronic care measured by patient survey: identification, selection and application of most appropriate instruments. *Health Expectations* Epub ahead of print 26/08/2009

<http://dx.doi.org/10.1111/j.1369-7625.2009.00557.x>

<http://pmid.us/19709315>

Objective To identify the most appropriate generic instrument to measure experience and/or satisfaction of people receiving integrated chronic care. Background Health care is becoming more user-centred and, as a result, the experience of users of care and evaluation of their experience and/or satisfaction is taken more seriously. It is unclear to what extent existing instruments are appropriate in measuring the experience and/or

satisfaction of people using integrated chronic care. Methods Instruments were identified by means of a systematic literature review. Appropriateness of instruments was analysed on seven criteria. The two most promising instruments were translated into Dutch, if necessary, and administered to a convenience sample of 109 people with a chronic illness. Data derived from respondents were analysed statistically. Focus-group interviews were conducted to assess the semantic and technical equivalence as well as opinions of people about the applicability and relevance of the translated instruments. Results From 37 instruments identified, the Patients' Assessment of Care for chronic Conditions (PACIC) and the short form of the Patient Satisfaction Questionnaire III (PSQ-18) were selected as most promising instruments. Both instruments produced similar median scores across people with different chronic conditions. The overall PACIC and its subscales and the overall PSQ-18 were highly internally consistent, but not the PSQ-18 subscales. Overall, the PACIC demonstrated better psychometric characteristics. PACIC and PSQ-18 scores were found to be moderately correlated. Whereas more respondents preferred the PSQ-18, focus-group participants regarded the PACIC to be more applicable and relevant. The technical and semantic equivalence of both instruments were sufficient. Conclusions Because of its psychometric characteristics, perceived applicability and relevance, the PACIC is the most appropriate instrument to measure the experience of people receiving integrated chronic care

Watts,J.J., & Segal,L. (2009). Market failure, policy failure and other distortions in chronic disease markets. *BMC Health Services Research* 9 102 18th June 2009

<http://dx.doi.org/10.1186/1472-6963-9-102>

<http://www.biomedcentral.com/1472-6963/9/102>

<http://pmid.us/19534822>

Background: The increasing prevalence of chronic disease represents a significant burden on most health systems. This paper explores the market failures and policy failures that exist in the management of chronic diseases. Discussion: There are many sources of market failure in health care that undermine the efficiency of chronic disease management. These include incomplete information as well as information asymmetry between providers and consumers, the effect of externalities on consumer behaviour, and the divergence between social and private time preference rates. This has seen government and policy interventions to address both market failures and distributional issues resulting from the inability of private markets to reach an efficient and equitable distribution of resources. However, these have introduced a series of policy failures such as distorted re-imburement arrangements across modalities and delivery settings. Summary: The paper concludes that market failure resulting from a preference of individuals for 'immediate gratification' in the form of health care and disease management, rather than preventative services, where the benefits are delayed, has a major impact on achieving an efficient allocation of resources in markets for the management of chronic diseases. This distortion is compounded by government health policy that tends to favour medical and pharmaceutical interventions further contributing

to distortions in the allocation of resources and inefficiencies in the management of chronic disease

COMMISSIONING

Peskett,S. (2009). The challenges of commissioning healthcare: a discussion paper. *International Journal of Health Planning and Management* 24(2), 95-112.

<http://dx.doi.org/10.1002/hpm.987>

<http://pmid.us/19504522>

The UK's Department of Health Independent Sector Programme to procure healthcare for National Health Service (NHS) patients from the independent sector revealed many of the challenges of commissioning, particularly assessing governance arrangements and identifying the organisational attributes of high quality healthcare providers. These issues were first discussed in a workshop at the British Association of Medical Managers (BAMM) Medical Directors Conference in Dublin in November 2007 (Dale, et al., 2009). The more difficult challenges of achieving effective clinical engagement, including motivational factors, organisational environment and systems and partnership working, in the complex field of commissioning healthcare in the UK are also explored here with particular reference to systems in other countries

COMORBIDITY

Koopmans,B., et al (2009). Associations between vascular co-morbidities and depression in insulin-naive diabetes patients: the DIAZOB Primary Care Diabetes study. *Diabetologia*. 9/08/2009 Epub ahead of print

<http://dx.doi.org/10.1007/s00125-009-1460-2>

<http://pmid.us/19669635>

Aims/hypothesis: The aim of the study was to determine the prevalence of depression in insulin-naive diabetes patients and to investigate the associations between different forms of vascular co-morbidity and depression. Methods: Cross-sectional data were used from a primary-care sample of 1,269 insulin-naive (i.e. not using insulin therapy) diabetes patients participating in the DIAZOB Primary Care Diabetes study. Demographics,

vascular co-morbidities, clinical and lifestyle characteristics, and psychosocial factors were assessed. Depression symptoms were measured with the Edinburgh Depression Scale, with a score >11 defined as depression. The chi (2) and Student's t tests were used to compare groups with and without vascular co-morbidities. Rates and odds ratios of depression were calculated for each vascular co-morbidity, with diabetes only as the reference group, correcting for age and sex. Single and multiple logistic regression analyses were performed to test a more comprehensive model regarding the likelihood of depression in diabetes. Results: The prevalence of depression was 11% in the total sample with little difference between the groups with and without any vascular co-morbidity (11.2% vs 10.0%). Single vascular co-morbidities were not associated with increased rates of depression. The final model predicting depression included: having multiple vascular co-morbidities compared with none; having less social support; having experienced a recent stressful life event; female sex; and being a smoker. Conclusions/interpretation: Rates of depression in those with one additional vascular co-morbidity did not differ from patients with diabetes only. Vascular co-morbidities were only associated with higher depression scores in case of multiple co-morbidities

O'Connor,P.J., et al (2009). Does diabetes double the risk of depression? *Annals of Family Medicine*, 7(4), 328-335.

<http://dx.doi.org/10.1370/afm.964>

<http://pmid.us/19597170>

Purpose: In this study, we compared the rate of depression diagnoses in adults with and without diabetes mellitus, while carefully controlling for number of primary care visits. Methods: We matched adults with incident diabetes (n = 2,932) or prevalent diabetes (n = 14,144) to nondiabetic control patients based on (1) age and sex, or (2) age, sex, and number of outpatient primary care visits. Logistic regression analysis was used to assess the association between various predictors and a diagnosis of depression in each diabetes cohort relative to matched nondiabetic control patients. Results: With matching for age and sex alone, patients with prevalent diabetes having few primary care visits were significantly more likely to have a new depression diagnosis than matched control patients (odds ratio [OR] = 1.46, 95% confidence interval [CI], 1.19-1.80), but this relationship diminished when patients made more than 10 primary care visits (OR = 0.95, 95% CI, 0.77-1.17). With additional matching for number of primary care visits, patients with prevalent diabetes mellitus with few primary care visits were more likely to have a new diagnosis of depression than those in control group (OR = 1.32, 95% CI, 1.07-1.63), but this relationship diminished and reversed when patients made more than 4 primary care visits (OR = 0.99, 95% CI, 0.80-1.23). Similar results were observed in the subset of patients with incident diabetes and their matched control patients. Conclusions: Patients with diabetes have little or no increase in the risk of a new diagnosis of depression relative to nondiabetic patients when analyses carefully control for the number of outpatient visits. Studies showing such an association may have inadequately adjusted for comorbidity or for exposure to the medical care system

Morrow,L.A., et al (2009). High medical co-morbidity and family history of dementia is associated with lower cognitive function in older patients. *Family Practice* . Epub ahead of print 7/07/2009

<http://dx.doi.org/10.1093/fampra/cmp047>

<http://pmid.us/19584123>

Background: Risk factors for cognitive decline in ageing are multifactorial, including medical co-morbidities and familial genetic risk. Objectives: To assess the effect of medical co-morbidity and family history of dementia on cognitive performance in older outpatients of family practitioners. Methods: Analysis of 535 outpatients from 11 practices aged 65 and older, without a diagnosis of dementia. Information on medical co-morbidities, family history of dementia and cognitive test data were obtained. Results: Patients were classified into high or low medical co-morbidities (<7 versus >8) and positive or negative family history of dementia. After controlling for age, education, gender and depression, global cognitive test scores, as well as memory, executive function, spatial ability and attention were significantly lower for persons having a high number of medical co-morbidities. Cognitive test scores were not significantly different for persons with or without a family history of dementia. A significant interaction between medical co-morbidities and family history of dementia was observed for the global cognitive score, executive function and spatial ability. Those persons with a high number of medical co-morbidities and positive family history of dementia had the lowest performance. Separate regression analysis assessing individual disease risk factors (e.g. hypertension and diabetes) did not find any relationship between specific medical variables and cognitive test scores for any of the subgroups. Conclusions: A high number of medical co-morbidities in addition to a reported family history of dementia are particularly detrimental to cognitive performance in elderly non-demented family practice patients

Ose,D., et al (2009). Impact of primary care-based disease management on the health-related quality of life in patients with type 2 diabetes and co-morbidity. *Diabetes Care*. 9/06/2009 Epub ahead of print

<http://dx.doi.org/10.2337/dc08-2223>

<http://pmid.us/19509007>

Objective: This study aimed to examine the effectiveness of the German diabetes disease management program (DMP) in patients with varying numbers of other medical conditions with respect to their health-related quality of life (HRQoL). Research design and methods: A questionnaire, including the HRQoL measure EQ-5D, was mailed to a random sample of 3,546 patients with type 2 diabetes (59.3% female). The EQ-5D score was analyzed by grouping patients according to those on a DMP and those receiving routine care. Results: The analysis showed that participation in the DMP ($p<0.001$), the number of other conditions ($p<0.001$) and the interaction between DMP and * number of

other conditions ($p < 0.05$) had a significant impact on the EQ-5D score. Conclusions: Our findings suggest that the number of other conditions may have a negative impact on the HRQoL of patients with type 2 diabetes. Our results demonstrate that the German DMP for type 2 diabetes may help counterbalance this effect

Spinhoven,P., et al (2009). The role of personality in comorbidity among anxiety and depressive disorders in primary care and specialty care: a cross-sectional analysis. *General Hospital Psychiatry*, 31(5), 470-477.

<http://dx.doi.org/10.1016/j.genhosppsy.2009.05.002>

<http://pmid.us/19703641>

Objective: Almost no cross-sectional studies directly compared the rate and pattern of comorbidity of affective disorders in relation to personality traits of patients seen in primary care versus specialty mental health care. Method: Using data from the Netherlands Study of Depression and Anxiety, we compared 1086 primary care patients with 790 consecutive specialized mental health care patients. All participants had at least one lifetime Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition-based diagnosis of depression or anxiety. Personality was assessed with the NEO Five-Factor Inventory. Results: In both settings it was common to have at least one lifetime comorbid affective disorder. Compared to primary care patients, specialty care patients showed elevated scores for Neuroticism and lower scores for Extraversion and Conscientiousness. The odds of having another disorder given any one disorder was no longer significant after accounting for personality dimensions. Only Neuroticism proved to be positively associated with comorbidity per se. Conclusions: Prevalence of and comorbidity among anxiety and depressive disorders in primary care were very similar to those in specialty care. Neuroticism - but no other personality traits - may help to understand the comorbidity among anxiety and depressive disorders irrespective of recruitment setting

Valderas,J.M., et al (2009). Defining comorbidity: implications for understanding health and health services. *Annals of Family Medicine*, 7(4), 357-363.

<http://dx.doi.org/10.1370/afm.983>

<http://pmid.us/19597174>

Comorbidity is associated with worse health outcomes, more complex clinical management, and increased health care costs. There is no agreement, however, on the meaning of the term, and related constructs, such as multimorbidity, morbidity burden, and patient complexity, are not well conceptualized. In this article, we review definitions of comorbidity and their relationship to related constructs. We show that the value of a given construct lies in its ability to explain a particular phenomenon of interest within the domains of (1) clinical care, (2) epidemiology, or (3) health services planning and financing. Mechanisms that may underlie the coexistence of 2 or more conditions in a

patient (direct causation, associated risk factors, heterogeneity, independence) are examined, and the implications for clinical care considered. We conclude that the more precise use of constructs, as proposed in this article, would lead to improved research into the phenomenon of ill health in clinical care, epidemiology, and health services

GOVERNANCE

Coleman,A., et al (2009). Scrutinizing local public service provision. *Public Money & Management*, 29(5), 299-306.

<http://dx.doi.org/10.1080/09540960903205949>

Set in the context of an expansion of scrutiny by local authorities of local service provision, this article explores the key challenges ahead for managers and politicians in this area of local governance. Drawing on an evaluation of the development of health scrutiny, it outlines the different types of activities health scrutiny committees are engaging in to fulfil their legislative commitments and suggests lessons for the expansion of external scrutiny

Fenton,L., & Salter,B. (2009). Competition and compromise in negotiating the new governance of medical performance: the clinical governance and revalidation policies in the UK. *Health Economics, Policy and Law*, 4(Pt 3), 283-303.

<http://dx.doi.org/10.1017/S1744133109005027>

<http://pmid.us/19467169>

This article explores the development of two policies for the governance of medical performance in the UK: the Department of Health's (DH) clinical governance policy and the medical profession's revalidation policy. After discussing the institutional context in which each of these policies emerged, we examine how and why they were constructed. While the clinical governance policy was in large part a swift reaction to high-profile cases of medical misconduct in the late 1990s, revalidation was the profession's response to the politicisation of its self-regulatory apparatus. The profession took notably longer than the DH to piece together its policy as a result of internal disagreements about the role clinical standards should play in the evaluation of a doctor's fitness to practice. Following the Fifth Report of the Shipman Inquiry in late 2004, the government stepped in and eventually introduced legislation that modifies the profession's policy. With

clinical governance, the state - via arms-length regulatory organisations - has entered the clinic in new ways, strengthening hierarchy-based forms of governance in the governance of medical performance. However, the success of hierarchical forms of governance is likely to be restricted by the lack of a clear system of sanctioning and the state's reliance on a lengthy chain of command in the National Health Service for the implementation of clinical standards

Litva,A., et al (2009). Lay perceptions of the desired role and type of user involvement in clinical governance. *Health Expectations* 12(1), 81-91.

<http://dx.doi.org/10.1111/j.1369-7625.2008.00530.x>

<http://pmid.us/19250154>

Objective: The aim of this paper is to explore variations in lay perceptions of user involvement in clinical governance. Context: The English National Health Service has sought to build a dependable health service through enhanced effectiveness, responsiveness and consistency. Clinical governance, a policy for improving service quality, is a key pillar of these reforms. It is a statutory duty of primary care organizations to ensure that users are involved in all service planning and decision making, including clinical governance. Yet surveys indicated that user involvement in clinical governance was underdeveloped and underutilized. Design: Focus groups were conducted with different types of lay people to explore their perceptions around public involvement in different aspects of clinical governance policy. Results: Content analysis of the transcripts reveals that different groups of lay people varied in their desired role perspective and preferred type of involvement in different aspects of clinical governance policy. Drawing upon existing models of user involvement, we identified three role perspectives that lay people could take in user involvement - consumer, advocate and citizen. We compared our findings regarding the desired type of involvement with existing models of user involvement, and identified a new type of involvement, overseeing, that is relevant to clinical governance policy. Conclusions: These findings suggest that to facilitate user involvement in clinical governance, it would be necessary to use different strategies to accommodate the differing role perspectives and types of involvement desired by different groups of lay people

Storey,J., & Holti,R. (2009). Sense-making by clinical and non-clinical executive directors within new governance arrangements. *Journal of Health Organization and Management* 23(2), 149-169.

<http://pmid.us/19711775>

Purpose: The purpose of this paper is to explore the various ways in which clinical executive directors and non-clinical executive directors are interpreting and responding to the extensive reforms and restructuring in the UK health service. Design/Methodology/Approach: The paper draws upon detailed research in two very large teaching hospital organizations in order to understand how actors crucial to the delivery of this vision are responding. Schedule-structured interviews with executive

directors were conducted, recorded, transcribed and coded. Findings: The clinical and non-clinical directors of these organizations engaged in a process of active sense-making are found, which is leading to significant changes to the service and also changes to identity. The clinical directors are revealing a willingness to assume accountability for devolved profit centres in their service lines. The non-clinical directors are supportive of this idea in broad terms but are cautious about releasing "too much" central control. Research limitations/Implications: The paper is based on just two case studies and the analyses are made through the perspectives of the executive teams in each case. Practical implications: Changes to healthcare environments of this kind are occurring in many countries, but such is the extent and intensity of these changes in the UK that the government's aspiration is high--it sees this set of reforms leading to a peerless world class health service. The way in which the actors make sense of and navigate their way through the cross cutting principles and the layered reforms is a critical issue. Originality/Value: There have been few systematic studies of the practical reality involved in the enactment of profit centre and service line management initiatives in acute hospital settings and the ways these are understood and negotiated at executive team level

Harrison,S. (2009). Co-Optation, commodification and the medical model: governing UK medicine since 1991. *Public Administration*, 87(2), 184-197.

<http://dx.doi.org/10.1111/j.1467-9299.2009.01752.x>

Self-regulation and autonomy are traditionally treated as distinctive elements of how professions are governed in contrast to other occupations. For medicine, these elements provide a collective medium of governance (through the institutions of professional self-regulation) and an individual medium (through the practice of 'clinical autonomy'). Both are reinforced by the intellectual dominance of the so-called 'biomedical model' of health and illness. Analysts generally agree that, in many countries, both self-regulation and clinical autonomy are under significant challenge. But it is less obvious that, in the UK at least, the biomedical model has effectively been co-opted for managerial purposes to support the commodification of medical care. Thus ideas that have traditionally been considered as supporting medical dominance have transpired to be a source of weakness for the profession

HEALTH ECONOMICS

Appleby,J., et al (2009). Searching for cost effectiveness thresholds in the NHS. *Health Policy*, 91(3), 239-245.

<http://dx.doi.org/10.1016/j.healthpol.2008.12.010>

<http://pmid.us/19168255>

Objectives: The UK's National Institute of Health and Clinical Excellence (NICE) has an explicit cost-effectiveness threshold for deciding whether or not services are to be

provided in the National Health Service (NHS), but there is currently little evidence to support the level at which it is set. This study examines whether it is possible to obtain such evidence by examining decision making elsewhere in the NHS. Its objectives are to set out a conceptual model linking NICE decision making based on explicit thresholds with the thresholds implicit in local decision making and to gauge the feasibility of (a) identifying those implicit local cost effectiveness thresholds and (b) using these to gauge the appropriateness of NICE's explicit threshold. Methods: Structured interviews with senior staff, together with financial and public health information, from six NHS purchasers and 18 providers. A list of health care services introduced or discontinued in 2006/7 was constructed. Those that were in principle amenable to estimation of a cost-effectiveness ratio were examined. Results: It was feasible to identify decisions and to estimate the cost-effectiveness of some. These were not necessarily 'marginal' services. Issues include: services that are dominated (or dominate); decisions about how, rather than what, services should be delivered; the lack of local cost effectiveness evidence; and considerations other than cost-effectiveness. Conclusions: A definitive finding about the consistency or otherwise of NICE and NHS cost effectiveness thresholds would require very many decisions to be observed, combined with a detailed understanding of the local decision making processes

Elliott,R., et al (2009). The role of the staff MFF in distributing NHS funding: taking account of differences in local labour market conditions. *Health Economics* Epub ahead of print 4/08/2009

<http://dx.doi.org/10.1002/hec.1489>

<http://pmid.us/19653330>

The National Health Service (NHS) in England distributes substantial funds to health-care providers in different geographical areas to pay for the health care required by the populations they serve. The formulae that determine this distribution reflect populations' health needs and local differences in the prices of inputs. Labour is the most important input and area differences in the price of labour are measured by the Staff Market Forces Factor (MFF). This Staff MFF has been the subject of much debate. Though the Staff MFF has operated for almost 30 years this is the first academic paper to evaluate and test the theory and method that underpin the MFF. The theory underpinning the Staff MFF is the General Labour Market method. The analysis reported here reveals empirical support for this theory in the case of nursing staff employed by NHS hospitals, but fails to identify similar support for its application to medical staff. The paper demonstrates the extent of spatial variation in private sector and NHS wages, considers the choice of comparators and spatial geography, incorporates vacancy modelling and illustrates the effect of spatial smoothing.

Peacock,S., et al (2009). Overcoming barriers to priority setting using interdisciplinary methods. *Health Policy*. Epub ahead of print 3/4/2009

<http://dx.doi.org/10.1016/j.healthpol.2009.02.006>

<http://pmid.us/19346024>

Ten years ago, Holm's highly influential paper "Goodbye to the simple solutions: the second phase of priority setting" was published [Holm S. Goodbye to the simple solutions: the second phase of priority setting in health care. *British Medical Journal* 1998;317:1000-7]. Whilst attending the 2nd International Conference on Priorities in Health Care in London, Holm argued that the search for a rational set of decision-making rules was no longer adequate. Instead, the priority setting process itself was now thought to be more complex. Ten years later, the Conference returns to the UK for the first time, and it is timely to describe some new tools intended to assist both researchers and decision-makers seeking to develop both rational and fair and legitimate priority setting processes. In this paper we argue that to do so, researchers and decision-makers need to adopt an interdisciplinary and collaborative approach to priority setting. We focus on program budgeting and marginal analysis (PBMA) and bring together three hitherto separate interdisciplinary strands of the PBMA literature. Our aim is to assist researchers and decision-makers seeking to effectively develop and implement PBMA in practice. Specifically, we focus on the use of multi-criteria decision analysis, participatory action research, and accountability for reasonableness, drawn from the disciplines of decision analysis, sociology, and ethics respectively

Scott, A., et al (2009). The effects of an incentive program on quality of care in diabetes management. *Health Economics* Email ahead of print 30/07/2009

<http://dx.doi.org/10.1002/hec.1536>

<http://pmid.us/19644938>

An incentive program for general practitioners to encourage systematic and high-quality care in chronic disease management was introduced in Australia in 1999. There is little empirical evidence and ambiguous theoretical guidance on which effects to expect. This paper evaluates the impact of the incentive program on quality of care in diabetes, as measured by the probability of ordering an HbA1c test. The empirical analysis is conducted with a unique data set and a bivariate probit model to control for the self-selection process of practices into the program. The study finds that the incentive program increased the probability of an HbA1c test being ordered by 20 percentage points and that participation in the program is facilitated by the support of Divisions of General Practice.

Scott,A., & Coote,W. (2009). Do regional primary-care organisations influence primary-care performance? A dynamic panel estimation. *Health Economics* Epub ahead of print 18/06/2009

<http://dx.doi.org/10.1002/hec.1509>

<http://pmid.us/19544284>

The role of regional primary-care organizations (PCOs) in health-care systems is not well understood. This is the first study to attempt to isolate the effect of regional PCOs on primary-care performance. We examine Divisions of General Practice in Australia, which were established in 1992. A unique Division-level panel data set is used to examine the effect of Divisions, and their activities, on various aspects of primary-care performance. Dynamic panel estimation is used to account for state dependence and the endogeneity of Divisions' activities. The results show that Divisions were more likely to have influenced general practice infrastructure than clinical performance in diabetes, asthma and cervical screening. The effect of specific Division activities, such as providing support for practice nurses and IT support, was not directly related to changes in the level of general practice performance. Specific support in the areas of diabetes and asthma was associated with general practice performance, but this was due to reverse causality and the effect of unobservable factors, rather than the direct effect of Divisions.

Segal,L., Dalziel,K., & Mortimer,D. (2009). Fixing the game: are between-silo differences in funding arrangements handicapping some interventions and giving others a head-start? *Health Economics* Epub ahead of print 20th April 2009

<http://dx.doi.org/10.1002/hec.1483>

<http://pmid.us/19382172>

Given resource scarcity, not all potentially beneficial health services can be funded. Choices are made, if not explicitly, implicitly as some health services are funded and others are not. But what are the primary influences on those choices? We sought to test whether funding decisions are linked to cost effectiveness and to quantify the influence of funding arrangements and community values arguments. We tested this via empirical analysis of 245 Australian health-care interventions for which cost-effectiveness estimates had been published. The likelihood of government funding was modelled as a function of cost effectiveness, patient/target group characteristics, intervention characteristics and publication characteristics, using multiple regression analysis. We found that higher cost effectiveness ratios were a significant predictor of funding rejection, but that cost effectiveness was not related to the level of funding. Intervention characteristics linked to funding and delivery arrangements and community values arguments were significant predictors of funding outcomes. Our analysis supports the hypothesis that funding and delivery arrangements influence both whether an intervention is funded and funding level; even after controlling for community values and cost effectiveness. It suggests that adopting partial priority setting processes without regard to opportunity cost can have the perverse effect of compounding allocative inefficiencies.

HEALTH INEQUALITIES

Bambra,C., et al (2009). Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews. *Journal of Epidemiology and Community Health* Epub ahead of print 19/08/2009

<http://dx.doi.org/10.1136/jech.2008.082743>

<http://pmid.us/19692738>

Background: There is increasing pressure to tackle the wider social determinants of health, through the implementation of appropriate interventions. However, turning these demands for better evidence about interventions around the social determinants of health into action requires identifying what we already know and highlighting the evidence gaps. Methods: Systematic review methodology was used to identify systematic reviews (from 2000-2007, developed countries only) that described the health effects of any intervention based on the wider social determinants of health: water and sanitation, agriculture and food, access to health and social care services, unemployment and welfare, work conditions, housing and living environment, education, and transport. Results: Thirty systematic reviews were identified. Certain categories of intervention may impact positively on health, in particular interventions in the fields of housing and work. However, there were clear gaps in the evidence, and the effects of interventions on health inequalities were unclear. Conclusion: Intervention studies which address inequalities in health are a priority area for future public health research

Rosa Dias P. (2009). Inequality of opportunity in health: evidence from a UK cohort study. *Health Economics* Epub ahead of print 30/07/2009

<http://dx.doi.org/10.1002/hec.1535>

<http://pmid.us/19644964>

This paper proposes an empirical implementation of the concept of inequality of opportunity in health and applies this to data from the UK National Child Development Study. Drawing on the distinction between circumstance and effort variables in John Roemer's work on equality of opportunity, circumstances are proxied by parental socio-economic status and childhood health; effort is proxied by health-related lifestyles and educational attainment. Stochastic dominance tests are used to detect inequality of opportunity in the conditional distributions of self-assessed health in adulthood. Two alternative approaches are used to measure inequality of opportunity. Econometric models are estimated to illuminate and quantify the triangular relationship between circumstances, effort and health. The results indicate the existence of a considerable and persistent inequality of opportunity in health. Circumstances affect health in adulthood both directly and through effort factors such as educational attainment. This indicates that, while the influence of some unjust circumstances can only be tackled during childhood, the implementation of complementary educational policies may be of paramount importance.

HEALTH POLICY

Currie,G., Koteyko,N., & Nerlich,B. (2009). The dynamics of professions and development of new roles in public services organizations: the case of modern matrons in the English NHS *Public Administration*, 87(2), 295-311.

<http://dx.doi.org/10.1111/j.1467-9299.2009.01755.x>

This study contributes to research examining how professional autonomy and hierarchy impacts upon the implementation of policy designed to improve the quality of public services delivery through the introduction of new managerial roles. It is based on an empirical examination of a new role for nurses - modern matrons - who are expected by policy-makers to drive organizational change aimed at tackling health care acquired infections (HCAI) in the National Health Service (NHS) within England. First, we show that the changing role of nurses associated with their ongoing professionalization limits the influence of modern matrons over their own ranks in tackling HCAI. Second, the influence of modern matrons over doctors is limited. Third, government policy itself appears inconsistent in its support for the role of modern matrons. The attempts of modern matrons to tackle HCAI appear more effective where infection control activity is situated in professional practice and where modern matrons integrate aspirations for improved infection control within mainstream audit mechanisms in a health care organization

Protheroe,J., et al (2009). Health literacy: setting an international collaborative research agenda. *BMC Family Practice*, 10(1), 51.

<http://dx.doi.org/10.1186/1471-2296-10-51>

<http://www.biomedcentral.com/1471-2296/10/51>

<http://pmid.us/19589176>

Background: Health literacy is an increasingly important topic in both the policy and research agendas of many countries. During the recent 36th Annual Meeting of the North American Primary Care Research Group, the authors led an audio-taped 3-hour forum, "Studying Health Literacy: Developing an International Collaboration," where the current state of health literacy (HL) in the United States (US) and United Kingdom (UK) was presented and attendees were encouraged to debate a future research agenda. Discussion of forum themes: The debate centred around three distinct themes, including: (1) refining HL definitions and conceptual models, (2) HL measurement and assessment tools, and (3) developing a collaborative international research agenda. The attendees agreed that future research should be theoretically grounded and conceptual models employed in studies should be explicit to allow for international comparisons to be drawn. Summary and authors reflections: The importance of HL research and its possible contribution to health disparities is becoming increasingly recognised internationally. International collaborations and comparative studies could illuminate some of the possible

determinants of disparities, and also possibly provide a vehicle to examine other research questions of interest

Sandy, L.G., et al (2009). The political economy of U.S. primary care. *Health Affairs (Millwood)*, 28(4), 1136-1145.

<http://dx.doi.org/10.1377/hlthaff.28.4.1136>

<http://pmid.us/19597213>

Compelling evidence suggests that the United States lags behind other developed nations in the health of its population and the performance of its health care system, partly as a result of a decades-long decline in primary care. This paper outlines the political, economic, policy, and institutional factors behind this decline. A large-scale, multifaceted effort--a new Charter for Primary Care--is required to overcome these forces. There are grounds for optimism for the success of this effort, which is essential to achieving health outcomes and health system performance comparable to those of other industrialized nations

INFORMATION AND COMMUNICATIONS TECHNOLOGY

McKinstry, B., et al (2009). Telephone consulting in primary care: a triangulated qualitative study of patients and providers. *British Journal of General Practice* 59(563), e209-e218

<http://dx.doi.org/10.3399/bjgp09X420941>

<http://pmid.us/19520019>

Background: Internationally, there is increasing use of telephone consultations, particularly for triaging requests for acute care. However, little is known about how this mode of consulting differs from face-to-face encounters. Aim: To understand patient and healthcare-staff perspectives on how telephone consulting differs from face-to-face consulting in terms of content, quality, and safety, and how it can be most appropriately incorporated into routine health care. Design of study: Focus groups triangulated by a national questionnaire. Setting: Primary care in urban and rural Scotland. Method: Fifteen focus groups (n = 91) were conducted with GPs, nurses, administrative staff, and patients, purposively sampled to attain a maximum-variation sample. Findings were triangulated by a national questionnaire. Results: Telephone consulting evolved in urban areas mainly to manage demand, while in rural areas it developed to overcome geographical problems and maintain continuity of care for patients. While telephone consulting was generally seen to provide improved access, clinicians expressed strong concerns about safety potentially being compromised, largely as a result of lack of formal and informal examination. Concerns were, to an extent, allayed when clinicians and patients knew each other well. Conclusion: Used appropriately, telephone consulting enhances access to

health care, aids continuity, and saves time and travelling for patients. The current emphasis on use for acute triage, however, worried clinicians and patients. Given these findings, and until the safe use of telephone triage is fully understood and agreed upon by stakeholders, policymakers and clinicians should consider using the telephone primarily for managing follow-up appointments when diagnostic assessment has already been undertaken

MEDICINES MANAGEMENT

Crowe,S., Tully,M.P., & Cantrill,J.A. (2009). The prescribing of specialist medicines: what factors influence GPs' decision making? *Family Practice* 26(4), 301-308.

<http://dx.doi.org/10.1093/fampra/cmp030>

<http://pmid.us/19505976>

Background: As Governments worldwide strive to integrate efficient health care delivery across the primary-secondary care divide, particular significance has been placed on the need to understand GPs' prescribing of specialist drugs. Objective: To explore the factors which influence GPs' decision-making process when requested to prescribe specialist drugs. Methods: A qualitative approach was used to explore the perspectives of a wide range of practice-, primary care trust-, strategic health authority-level staff and other relevant stakeholders in the North-West of England. All semi-structured interviews (n = 47) were analysed comprehensively using the five-stage 'framework' approach. Results: Six diverse factors were identified as having a crucial bearing on how GPs evaluate initial requests and subsequently decide whether or not to prescribe. These include GPs' lack of knowledge and expertise in using specialist drugs, the shared care arrangement, the influence of a locally agreed advisory list, financial and resource considerations, patient convenience and understanding and GPs' specific areas of interest. Conclusion: This exploration of GPs' decision-making process is needed to support future integrated health care delivery

Haslbeck,J.W., & Schaeffer,D. (2009). Routines in medication management: the perspective of people with chronic conditions. *Chronic Illness* Epub ahead of print 5th August 2009

<http://dx.doi.org/10.1177/1742395309339873>

<http://pmid.us/19656813>

Objective: To focus on the challenges and problems of medication management in everyday life experienced by people with chronic conditions, giving special attention to chronic illness trajectories. Methods: Using a grounded theory approach, in-depth and follow-up interviews with 27 chronically ill people were conducted and analysed. Results: From the perspective of people with chronic conditions, the main challenge in everyday medication management was to develop, maintain, and adjust routines. Routines were affected by the chronic illness trajectory and a variety of barriers. Developing and adjusting routines was further complicated by inadequate information and counselling, asymmetric relationships and communication with healthcare professionals, restrictive healthcare conditions, increasing complexities in medication regimens as well as healthcare professionals' lack of interest in the problems of chronically ill people balancing their chronic condition and medication regimen in everyday life. Discussion: Chronically ill persons have to deal with numerous difficulties in everyday medication management on their own. They are often overwhelmed by problems related to both their medication regimen and their routines in medication (self-) management. Thus, they require individualized long-term self-management support. Future research should address the dynamic nature of chronic illness trajectories and focus on later phases of chronic conditions

Gray, N. (2006). Evaluation of the community pharmacy element of an information prescriptions pilot. *Primary Health Care Research & Development, Forthcoming(-1), 1-11.*

<http://dx.doi.org/10.1017/S1463423609990181>

Aim The aim of this paper is to describe the experience of community pharmacists participating in a pilot of an information prescription service aimed at children and their parents, in the wider context of factors relevant to the adoption of new services in community pharmacies. **Background** Information prescriptions (IP) are conceived to signpost patients to information and advice that will increase self-efficacy. The Department of Health for England has supported IP development with a national programme of pilots, only one of which incorporated distribution of IP through community pharmacies. The new contract for community pharmacy, implemented in 2005, formalized cognitive services, including information-giving about medicines and health, and positioned signposting as a core activity. There are, however, concerns about the impact of such services on the capacity of community pharmacy. **Methods** Qualitative semi-structured telephone interviews were conducted with key informants: seven pharmacists in four IP pilot community pharmacies in England (), and 22 other pharmacy and medicines information stakeholders. Two interviews were conducted with each IP pilot pharmacist (before and during the pilot), and one with all other stakeholders. **Findings** IP pharmacists, and other stakeholders, identified a number of benefits for parents of children with long-term conditions in receiving IP, and hoped that most parents would welcome the service. Many anticipated operational challenges consistent with those of other new cognitive community pharmacy services, such as medicines use review. Pharmacists completing IP for parents found it satisfying and straightforward. Recruitment of parents to the pilot, however, fell below IP pharmacists condition, was

both surprising and disappointing to them. IP should be integrated into a wider, integrated medicines and information strategy

Ohlsson,H., Lynch,K., & Merlo,J. (2009). Is the physician's adherence to prescription guidelines associated with the patient's socioeconomic position? - An analysis of statin prescription in South Sweden. *Journal of Epidemiology and Community Health* Epub ahead of print 19/08/2009

<http://dx.doi.org/10.1136/jech.2008.081166>

<http://pmid.us/19692716>

Background: Knowledge about the social and economical determinants of prescription is relevant in health care systems like the Swedish one, which is based on the principle of equity, and which aims to allocate resources on the basis of need and not on criteria that are based on social constructs. We therefore investigated the association between patient and health care practice (HCP) characteristics on the one hand, and adherence to guidelines for statin prescription on the other, with a focus on social and economic conditions. Methods: The study included all patients in the Skane region of Sweden who received a statin prescription between July 2005 and December 2005; 15 581 patients in 139 privately-administered HCPs and 24 593 patients in 142 publicly-administered HCPs. Socioeconomic status was established using data from LOMAS (Longitudinal Multilevel Analysis in Skane), and stratified multilevel regression analysis was performed. Results: The proportion of patients receiving recommended statins was lower among privately-administered HCPs than among publicly-administered HCPs (65% vs. 80%). Among men (but not women), low income (PR_{privateHCP} = 1.04 (1.01-1.09) and PR_{publicHCP} = 1.02 (0.99-1.07)) and cohabitation (PR_{privateHCP} = 1.04 (1.04-1.08) and PR_{publicHCP} = 1.03 (1.01-1.07)) were associated with higher adherence to guidelines. Conclusion: The physician's decision to prescribe a recommended statin is conditioned by the socioeconomic and demographic characteristics of the patient. Beyond individual characteristics, the contextual circumstances of the HCP were also associated with adherence to guidelines. An increased understanding of the connection between the patient's socioeconomic status and the decisions made by the physician might be of relevance when planning interventions aimed at promoting efficient and evidence-based prescription

Wensing,M., et al (2009). Quality circles to improve prescribing of primary care physicians. Three comparative studies. *Pharmacoepidemiology and Drug Safety* 8/06/2009 Epub ahead of print

<http://dx.doi.org/10.1002/pds.1778>

<http://pmid.us/19507170>

Purpose: To determine the effectiveness of quality circles on prescribing patterns of primary care physicians in Germany and to explore the influence of specific factors on changes. Methods: Three large non-randomised comparative studies were performed in

primary care in Germany, with baseline measurements in 2001 and follow-up measurements in 2003. 1090 physicians were in intervention groups and 2090 physicians in control groups. For each physician, data on 444 patients and 1201 prescriptions were available, on average, at each measurement moment. Quality circles comprising of a series of small group moderated meetings of physicians, provision of evidence-based information and repeated written feedback on individual prescribing patterns. Results: Compared to the control groups, physicians in the intervention groups reduced mean prescription cost per patient per 3-month period by 1.87 euro (95%CI 0.51 to 3.22), increased generic drugs of all potentially generic prescriptions by 0.75% (95%CI 0.40 to 1.10), increased prescription of recommended lipid lowering drugs by 4.24% (95%CI 2.40 to 6.10), increased the prescription of recommended antibiotics by 1.72% (95%CI 0.33 to 3.10). Groups with more positive views of performance feedback, evidence-based indicators and price comparisons showed more change of prescribing. Conclusions: Quality circles had a modest effect on prescribing quality and costs. If widely implemented, they could have nationwide impact on the quality and costs of prescribing in primary care.

Sayers,Y.M., Armstrong,P., & Hanley,K. (2009). Prescribing errors in general practice: A prospective study. *European Journal of General Practice, 15(2), 81-83.*

<http://dx.doi.org/10.1080/13814780802705984>

<http://pmid.us/19169911>

Prescribing is one of the commonest tasks in daily general practice. Surprisingly there is little published research on errors that occur in this area. The aim of this study was to estimate the seriousness and level of prescribing errors that occurred in general practice. This prospective survey documented errors in prescriptions from 28 general practitioners as they occurred over a 3-day period in 12 community pharmacies. From a total of 3,948 prescriptions, 491 (12.4%) contained one or more errors. From a total of 8,686 drug items, 546 (6.2%) contained one or more errors. Of the errors the majority were minor (398, 72.9%), a smaller number (135, 24.7%) were major nuisance errors, and there were 13 (2.4%) potentially serious errors. The most common errors related to drug directions and dosage

Wettermark,B.,et al (2009). Financial incentives linked to self-assessment of prescribing patterns: a new approach for quality improvement of drug prescribing in primary care. *Quality in Primary Care, 17(3), 179-189.*

<http://pmid.us/19622268>

Background: Financial incentives have been suggested to be effective in increasing the quality and efficiency of drug prescribing. Concern has been raised in relation to potential negative consequences on the quality of care. AIMS: To describe and analyse the impact of an incentives model linking payment with adherence to drug and therapeutics committee (DTC) guidelines and self-reflection of prescribing pattern in a 'prescribing

quality report'. **MethodS:** The study was performed in the county of Stockholm, Sweden, with 139 (out of 154) primary healthcare centres (PHCs) participating in the project and 15 PHCs not participating. The study consisted of two parts: a quantitative observational study of prescribing patterns and a qualitative analysis of the submitted prescribing quality reports. All prescriptions issued from PHCs and dispensed at pharmacies during October to December 2005 and October to December 2006 were analysed, using adherence to the regional DTC guidelines as the main outcome measure. Adherence was assessed using the drug utilisation 90% methodology, i.e. focusing on drugs constituting 90% of the prescribed volume and the proportion of drugs included in the guidelines. The qualitative analysis focused on reports on the quality of drug prescribing submitted by each PHC in early 2007. **Results:** The 139 PHCs participating in the programme accounted for 85% of all prescriptions issued in primary care during October to December 2006. Mean adherence to guidelines increased among participating practices by 3.3 percentage units (95% confidence interval (CI) 2.9-3.7%) to 83% (82.6-83.7%) during the year. The adherence among practices not participating increased by 3.1 percentage units (95% CI 1.7-4.4%) to 78.8% (95% CI 76.7-80.9%). The higher adherence achieved during the year corresponded to savings estimated at five times greater than the cost of running the programme including the financial incentives. In addition, many areas for improving prescribing were identified, such as limiting the prescribing of drugs with uncertain safety profiles and documentation as well as reporting adverse drug reactions. **Conclusion:** Although no causal effect can be attributed without a control group, we have shown the feasibility of a model linking payment to DTC adherence. This approach with its own quality assessment and goal setting offers an example to other regions and countries of how to increase the quality and efficiency of drug prescribing within limited resources

MENTAL HEALTH

Bakker,I.M., et al (2009). Training GP's to use a minimal intervention for stress-related mental disorders with sick leave (MISS): Effects on performance Results of the MISS project; a cluster-randomised controlled trial [ISRCTN43779641]. *Patient Education and Counseling*

<http://dx.doi.org/10.1016/j.pec.2009.07.006>

<http://pmid.us/19647973>

Objective: To study the effects of a brief patient-stress management training on the performance of general practitioners (GPs). **MethodS:** After training in the Minimal Intervention for Stress-related mental disorders with Sick leave (MISS), the performance of 24 GPs was compared with the usual care provided by 22 GPs. Outcome measures in this intervention were: assignment of a diagnosis, taking an activating approach and monitoring the symptoms. **Results:** Twenty-three GPs completed the training. Outcomes showed that the training added to a psychosocial diagnosis. Other skills (using a questionnaire to make a diagnosis, handing out information leaflets and monitoring the symptoms) were to some extent improved by the training. **Conclusion:** The result

indicates limited adherence of GPs to the MISS. Only a few components of the training were actually applied after the training, and there is still ample room for improvement. Practice implications: More than the current 11h of training are probably needed to change the behaviour of GPs in general. Within educational programmes more attention should be given to the implementation of new behaviour, particularly when it concerns the treatment of patients with stress-related problems

Beattie,A., et al (2009). Primary-care patients' expectations and experiences of online cognitive behavioural therapy for depression: a qualitative study. *Health Expectations* 12(1), 45-59.

<http://dx.doi.org/10.1111/j.1369-7625.2008.00531.x>

<http://pmid.us/19250152>

Objective: To explore expectations and experiences of online cognitive behavioural therapy (CBT) among primary-care patients with depression, focusing on how this mode of delivery impacts upon the therapeutic experience. Design: Qualitative study, using repeat semi-structured interviews with patients before and after therapy. The study was conducted in parallel with a randomized controlled trial examining the effectiveness and cost-effectiveness of online CBT for patients with depression. Participants: Twenty-four patients with depression recruited from five general practices in southwest England, who were offered up to 10 sessions of CBT, delivered via the internet by a psychologist. Results: Most participants accessed the therapy from their home computer and found this to be a major advantage, in terms of convenience and fitting therapy into their daily routine, with any technical problems quickly resolved. Two key themes regarding expectations and experiences of online CBT were: developing a virtual relationship with a therapist, and the process of communicating thoughts and emotions via an online medium. Online CBT seems to be acceptable to, and experienced as helpful by, certain subgroups of patients with depression, particularly those who are familiar with computers, feel comfortable with writing their feelings down, enjoy the opportunities to review and reflect that written (or typed) communication offers are attracted to the 'anonymity' of an online therapeutic relationship and are open to the proactive requirements of CBT itself. However, on-line CBT may feed into the vulnerability of depressed people to negative thoughts, given the absence of visual cues and the immediate response of face-to-face interaction. Conclusions: Online CBT has the potential to enhance care for patients with depression who are open to engaging in 'talking' (or typing) therapies as part of their treatment. If online CBT is to be provided via the NHS, it is important to establish patient preferences regarding this mode of delivery and ensure that referral practices are appropriately targeted. The results of our main trial will provide evidence regarding the effectiveness and cost-effectiveness of receiving therapy via this modality

Franx, G., et al (2009). Quality improvement in depression care in the Netherlands: the Depression Breakthrough Collaborative. A quality improvement report. *International Journal of Integrated Care*, 9 e84.

<http://pmid.us/19590610>

Background: Improving the healthcare for patients with depression is a priority health policy across the world. Roughly, two major problems can be identified in daily practice: (1) the content of care is often not completely consistent with recommendations in guidelines and (2) the organization of care is not always integrated and delivered by multidisciplinary teams. Aim: To describe the content and preliminary results of a quality improvement project in primary care, aiming at improving the uptake of clinical depression guidelines in daily practice as well as the collaboration between different mental health professionals. Method: A Depression Breakthrough Collaborative was initiated from December 2006 until March 2008. The activities included the development and implementation of a stepped care depression model, a care pathway with two levels of treatment intensity: a first step treatment level for patients with non-severe depression (brief or mild depressive symptoms) and a second step level for patients with severe depression. Twelve months data were measured by the teams in terms of one outcome and several process indicators. Qualitative data were gathered by the national project team with a semi-structured questionnaire amongst the local team coordinators. Results: Thirteen multidisciplinary teams participated in the project. In total 101 health professionals were involved, and 536 patients were diagnosed. Overall 356 patients (66%) were considered non-severely depressed and 180 (34%) patients showed severe symptoms. The mean percentage of non-severe patients treated according to the stepped care model was 78%, and 57% for the severely depressed patient group. The proportion of non-severely depressed patients receiving a first step treatment according to the stepped care model, improved during the project, this was not the case for the severely depressed patients. The teams were able to monitor depression symptoms to a reasonable extent during a period of 6 months. Within 3 months, 28% of monitored patients had recovered, meaning a Beck Depression Inventory (BDI) score of 10 and lower, and another 27% recovered between 3 and 6 months. Conclusions and Discussion: A stepped care approach seems acceptable and feasible in primary care, introducing different levels of care for different patient groups. Future implementation projects should pay special attention to the quality of care for severely depressed patients. Although the Depression Breakthrough Collaborative introduced new treatment concepts in primary and specialty care, the change capacity of the method remains unclear. Thorough data gathering is needed to judge the real value of these intensive improvement projects

de Graaf,L.E., et al (2009). Clinical effectiveness of online computerised cognitive-behavioural therapy without support for depression in primary care: randomised trial. *The British Journal of Psychiatry*, 195(1), 73-80.

<http://dx.doi.org/10.1192/bjp.bp.108.054429>

<http://pmid.us/19567900>

Background Computerised cognitive-behavioural therapy (CCBT) might offer a solution to the current undertreatment of depression. Aims To determine the clinical effectiveness of online, unsupported CCBT for depression in primary care. Method Three hundred and

three people with depression were randomly allocated to one of three groups: Colour Your Life; treatment as usual (TAU) by a general practitioner; or Colour Your Life and TAU combined. Colour Your Life is an online, multimedia, interactive CCBT programme. No assistance was offered. We had a 6-month follow-up period. Results No significant differences in outcome between the three interventions were found in the intention-to-treat and per protocol analyses. Conclusions Online, unsupported CCBT did not outperform usual care, and the combination of both did not have additional effects. Decrease in depressive symptoms in people with moderate to severe depression was moderate in all three interventions. Online CCBT without support is not beneficial for all individuals with depression

Kessler,D., et al (2009). Therapist-delivered internet psychotherapy for depression in primary care: a randomised controlled trial. *Lancet*, 374(9690), 628-634.

[http://dx.doi.org/10.1016/S0140-6736\(09\)61257-5](http://dx.doi.org/10.1016/S0140-6736(09)61257-5)

<http://pmid.us/19700005>

Background: Despite strong evidence for its effectiveness, cognitive-behavioural therapy (CBT) remains difficult to access. Computerised programs have been developed to improve accessibility, but whether these interventions are responsive to individual needs is unknown. We investigated the effectiveness of CBT delivered online in real time by a therapist for patients with depression in primary care. Methods: In this multicentre, randomised controlled trial, 297 individuals with a score of 14 or more on the Beck depression inventory (BDI) and a confirmed diagnosis of depression were recruited from 55 general practices in Bristol, London, and Warwickshire, UK. Participants were randomly assigned, by a computer-generated code, to online CBT in addition to usual care (intervention; n=149) or to usual care from their general practitioner while on an 8-month waiting list for online CBT (control; n=148). Participants, researchers involved in recruitment, and therapists were masked in advance to allocation. The primary outcome was recovery from depression (BDI score <10) at 4 months. Analysis was by intention to treat. This trial is registered, number ISRCTN 45444578. Findings: 113 participants in the intervention group and 97 in the control group completed 4-month follow-up. 43 (38%) patients recovered from depression (BDI score <10) in the intervention group versus 23 (24%) in the control group at 4 months (odds ratio 2.39, 95% CI 1.23-4.67; p=0.011), and 46 (42%) versus 26 (26%) at 8 months (2.07, 1.11-3.87; p=0.023). Interpretation: CBT seems to be effective when delivered online in real time by a therapist, with benefits maintained over 8 months. This method of delivery could broaden access to CBT.

Oud,M.J., et al (2009). Care for patients with severe mental illness: the general practitioner's role perspective. *BMC Family Practice* 10 29

<http://dx.doi.org/10.1186/1471-2296-10-29>

<http://www.biomedcentral.com/1471-2296/10/29>

<http://pmid.us/19419547>

Background: Patients with severe mental illness (SMI) experience distress and disabilities in several aspects of life, and they have a higher risk of somatic co-morbidity. Both patients and their family members need the support of an easily accessible primary care system. The willingness of general practitioners and the impeding factors for them to participate in providing care for patients with severe mental illness in the acute and the chronic or residual phase were explored. Methods: A questionnaire survey of a sample of Dutch general practitioners spread over the Netherlands was carried out. This comprised 20 questions on the GP's 'Opinion and Task Perspective', 19 questions on 'Treatment and Experiences', and 27 questions on 'Characteristics of the General Practitioner and the Practice Organisation'. Results: 186 general practitioners distributed over urban areas (49%), urbanised rural areas (38%) and rural areas (15%) of the Netherlands participated. The findings were as follows: GPs currently considered themselves as the first contact in the acute psychotic phase. In the chronic or residual phase GPs saw their core task as to diagnose and treat somatic co-morbidity. A majority would be willing to monitor the general health of these patients as well. It appeared that GP trainers and GPs with a smaller practice setting made follow-up appointments and were willing to monitor the self-care of patients with SMI more often than GPs with larger practices. GPs also saw their role as giving support and information to the patient's family. However, they felt a need for recognition of their competencies when working with mental health care specialists. Conclusion: GPs were willing to participate in providing care for patients with SMI. They considered themselves responsible for psychotic emergency cases, for monitoring physical health in the chronic phase, and for supporting the relatives of psychotic patients

McPherson,S., & Armstrong,D. (2009). Negotiating 'depression' in primary care: A qualitative study. *Social Science and Medicine* Online 13/06/2009

<http://dx.doi.org/10.1016/j.socscimed.2009.05.032>

<http://pmid.us/19527919>

Psychiatry has provided primary care physicians with tools for recognising and labelling mild, moderate or severe 'depression'. General practitioners (GPs) in the UK have been guided to manage depression within primary care and to prescribe anti-depressants as a first-line treatment. The present study aimed to examine how GPs would construct 'depression' when asked to talk about those anomalous patients for whom the medical frontline treatment did not appear to be effective. Twenty purposively selected GPs were asked in an interview to talk about their experience and management of patients with depression who did not respond to anti-depressants. GPs initially struggled to identify a group, but then began to construct a category of person with a pre-medicalised status characterised by various deviant features such as unpleasant characters and personalities, manipulative tendencies, people with entrenched social problems unable to fit in with other people and relate to people normally. GPs also responded in non-medical ways including feeling unsympathetic, breaking confidentiality and prescribing social interventions. In effect, in the absence of an effective medical treatment, depression

appeared to become demedicalised. The implications of this process are discussed in relation to patients' subsequent access or lack of access to services and the way in which these findings highlight the processes by which medicine frames disease

Mitchell,A.J., Vaze,A., & Rao,S. (2009). Clinical diagnosis of depression in primary care: a meta-analysis. *Lancet*. Online 27/7/2009

[http://dx.doi.org/10.1016/S0140-6736\(09\)60879-5](http://dx.doi.org/10.1016/S0140-6736(09)60879-5)

<http://pmid.us/19640579>

Background: Depression is a major burden for the health-care system worldwide. Most care for depression is delivered by general practitioners (GPs). We assessed the rate of true positives and negatives, and false positives and negatives in primary care when GPs make routine diagnoses of depression. Methods: We undertook a meta-analysis of 118 studies that assessed the accuracy of unassisted diagnoses of depression by GPs. 41 of these studies were included because they had a robust outcome standard of a structured or semi-structured interview. Findings: 50 371 patients were pooled across 41 studies and examined. GPs correctly identified depression in 47.3% (95% CI 41.7% to 53.0%) of cases and recorded depression in their notes in 33.6% (22.4% to 45.7%). 19 studies assessed both rule-in and rule-out accuracy; from these studies, the weighted sensitivity was 50.1% (41.3% to 59.0%) and specificity was 81.3% (74.5% to 87.3%). At a rate of 21.9%, the positive predictive value was 42.0% (39.6% to 44.3%) and the negative predictive value was 85.8% (84.8% to 86.7%). This finding suggests that for every 100 unselected cases seen in primary care, there are more false positives (n=15) than either missed (n=10) or identified cases (n=10). Accuracy was improved with prospective examination over an extended period (3-12 months) rather than relying on a one-off assessment or case-note records. Interpretation: GPs can rule out depression in most people who are not depressed; however, the modest prevalence of depression in primary care means that misidentifications outnumber missed cases. Diagnosis could be improved by re-assessment of individuals who might have depression. Funding: None

Poutanen,O., et al (2009). Gender differences in the symptoms of major depression and in the level of social functioning in public primary care patients. *European Journal of General Practice* Epub ahead of print 14/08/2009

<http://dx.doi.org/10.1080/13814780903186423>

<http://pmid.us/19685381>

Background: There are no great differences in the symptom profiles of depression between the genders in observer rating scales, but women self-report more symptoms. Objective: To compare gender differences in symptom profiles of clinical depression in primary care with a short self-report depression scale and an observer-rated scale for social functioning. Methods: A sample of 436 primary care patients aged 18-64 years were screened using the Depression Scale (DEPS) and interviewed using the Present State Examination (PSE). Level of social functioning was also assessed. Sum scores and

single items of DEPS were compared between men and women in the groups of both depressive and non-depressive patients, and the interactions between gender and depression were analysed. Results: Depressive men scored poorer on both instruments. Feeling that everything is an effort and feeling worthless were typical for depressive men. Feeling blue was more typical for non-depressive women than for non-depressive men. Conclusion: In this sample of primary care patients, there were differences in the symptom profiles of depression between men and women. Depressive men more commonly had serious symptoms than depressive women. Clinically, male depression deserves more attention. The psychosocial profile of public primary care patients in Finland warrants further research

Terluin,B., et al (2009). Detecting depressive and anxiety disorders in distressed patients in primary care; comparative diagnostic accuracy of the Four-Dimensional Symptom Questionnaire (4DSQ) and the Hospital Anxiety and Depression Scale (HADS). *BMC Family Practice*, 10(1), 58.

<http://dx.doi.org/10.1186/1471-2296-10-58>

<http://www.biomedcentral.com/1471-2296/10/58>

<http://pmid.us/19698153>

Background: Depressive and anxiety disorders often go unrecognized in distressed primary care patients, despite the overtly psychosocial nature of their demand for help. This is especially problematic in more severe disorders needing specific treatment (e.g. antidepressant pharmacotherapy or specialized cognitive behavioural therapy). The use of a screening tool to detect (more severe) depressive and anxiety disorders may be useful not to overlook such disorders. We examined the accuracy with which the Four-Dimensional Symptom Questionnaire (4DSQ) and the Hospital Anxiety and Depression Scale (HADS) are able to detect (more severe) depressive and anxiety disorders in distressed patients, and which cut-off points should be used. Methods: Seventy general practitioners (GPs) included 295 patients on sick leave due to psychological problems. They excluded patients with recognized depressive or anxiety disorders. Patients completed the 4DSQ and HADS. Standardized diagnoses of DSM-IV defined depressive and anxiety disorders were established with the Composite International Diagnostic Interview (CIDI). Receiver Operating Characteristic (ROC) analyses were performed to obtain sensitivity and specificity values for a range of scores, and area under the curve (AUC) values as a measure of diagnostic accuracy. Results: With respect to the detection of any depressive or anxiety disorder (180 patients, 61%), the 4DSQ and HADS scales yielded comparable results with AUC values between 0.745 and 0.815. Also with respect to the detection of moderate or severe depressive disorder, the 4DSQ and HADS depression scales performed comparably (AUC 0.780 and 0.739, p 0.165). With respect to the detection of panic disorder, agoraphobia and social phobia, the 4DSQ anxiety scale performed significantly better than the HADS anxiety scale (AUC 0.852 versus 0.757, p 0.001). The recommended cut-off points of both HADS scales appeared to be too low while those of the 4DSQ anxiety scale appeared to be too high. Conclusions: In general practice patients on sick leave because of psychological problems, the 4DSQ and the

HADS are equally able to detect depressive and anxiety disorder. However, for the detection of cases severe enough to warrant specific treatment, the 4DSQ may have some advantages over the HADS, specifically for the detection of panic disorder, agoraphobia and social phobia

Uegaki,K., et al (2009). Cost-effectiveness of a minimal intervention for stress-related sick leave in general practice: Results of an economic evaluation alongside a pragmatic randomised control trial. *Journal of Affective Disorders*. Epub 11/5/2009

<http://dx.doi.org/10.1016/j.jad.2009.04.012>

<http://pmid.us/19439362>

Background: Stress-related mental health problems negatively impact quality of life and productivity. Worldwide, treatment is often sought in primary care. Our objective was to determine whether a general practitioner-based minimal intervention for workers with stress-related sick leave (MISS) was cost-effective compared to usual care (UC). Methods: We conducted an economic evaluation from a societal perspective. Quality-adjusted life years (QALYs) and resource use were measured by the EuroQol and cost diaries, respectively. Uncertainty was estimated by 95% confidence intervals, cost-effectiveness planes and acceptability curves. Sensitivity analyses and ancillary analyses based on preplanned subgroups were performed. Results: No statistically significant differences in costs or QALYs were observed. The mean incremental cost per QALY was -euro7356 and located in the southeast quadrant of the cost-effectiveness plane, whereby the intervention was slightly more effective and less costly. For willingness-to-pay (λ) thresholds from euro0 to euro100,000, the probability of MISS being cost-effective was 0.58-0.90. For the preplanned subgroup of patients diagnosed with stress-related mental disorders, the incremental ratio was -euro28,278, again in the southeast quadrant. Corresponding probabilities were 0.92 or greater. Limitations: Non-significant findings may be related to poor implementation of the MISS intervention and low power. Also, work-presenteeism and unpaid labor were not measured. Conclusions: The minimal intervention was not cost-effective compared to usual care for a heterogeneous patient population. Therefore, we do not recommend widespread implementation. However, the intervention may be cost-effective for the subgroup stress-related mental disorders. This finding should be confirmed before implementation for this subgroup is considered

van Rijswijk,E. et al (2009). Barriers in recognising, diagnosing and managing depressive and anxiety disorders as experienced by Family Physicians; a focus group study. *BMC Family Practice*, 10(1), 52.

<http://dx.doi.org/10.1186/1471-2296-10-52>

<http://www.biomedcentral.com/1471-2296/10/52/abstract>

<http://pmid.us/19619278>

Background: The recognition and treatment of depressive- and anxiety disorders is not always in line with current standards. The results of programs to improve the quality of care, are not encouraging. Perhaps these programs do not match with the problems experienced in family practice. This study aims to systematically explore how FPs perceive recognition, diagnosis and management of depressive and anxiety disorders. Method: focus group discussions with FPs, qualitative analysis of transcriptions using thematic coding. Results: The FPs considered recognising, diagnosing and managing depressive- and anxiety disorders as an important task. They expressed serious doubts about the validity and usefulness of the DSM IV concept of depressive and anxiety disorders in family practice especially because of the high frequency of swift natural recovery. An important barrier was that many patients have difficulties in accepting the diagnosis and treatment with antidepressant drugs. FPs lacked guidance in the assessment of patients' burden. The FPs experienced they had too little time for patient education and counseling. The under capacity of specialised mental health care and its minimal collaboration with FPs were experienced as problematic. Valuable suggestions for solving the problems encountered were made. Conclusions: Next to serious doubts regarding the diagnostic concept of depressive- and anxiety disorders a number of factors were identified which serve as barriers for suitable mental health care by FPs. These doubts and barriers should be taken into account in future research and in the design of interventions to improve mental health care in family practice

Wittkamp, K., et al (2009). The accuracy of Patient Health Questionnaire-9 in detecting depression and measuring depression severity in high-risk groups in primary care. *General Hospital Psychiatry*, 31(5), 451-459.

<http://dx.doi.org/10.1016/j.genhosppsych.2009.06.001>

<http://pmid.us/19703639>

Objective: Only half of patients with depressive disorder are diagnosed by their family physicians. Screening in high-risk groups might reduce this hidden morbidity. This study aims to determine the accuracy of the Patient Health Questionnaire-9 (PHQ-9) in (a) screening for depressive disorder, (b) diagnosing depressive disorder and (c) measuring the severity of depressive disorder in groups that are at high risk for depressive disorder. Method: We compared the performance of the PHQ-9 as a screening instrument and as a diagnostic instrument to that of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) interview, which we used as reference standard. Three high-risk groups of patients were selected: (a) frequent attenders, (b) patients with mental health problems and (c) patients with unexplained complaints. Patients completed the PHQ-9. Next, patients who were at risk for depression (based on PHQ scores) and a random sample of 20% of patients who were not at risk were selected for a second PHQ-9 and the reference standard (SCID-I). We assessed the adequacy of the PHQ-9 as a tool for severity measurement by comparing PHQ-9 scores with scores on the 17-item Hamilton Depression Rating Scale (HDRS-17) in patients diagnosed with a depressive disorder. Results: Among 440 patients, both PHQ-9 and SCID-I were analyzed. The test

characteristics for screening were sensitivity=0.93 and specificity=0.85; those for diagnosing were sensitivity=0.68 and specificity=0.95. The positive likelihood ratio for diagnosing was 14.2. The HDRS-17 was administered in 49 patients with depressive disorder. The Pearson correlation coefficient of the PHQ-9 to the HDRS-17 was $r=.52$ ($P<.01$). Conclusion: The PHQ-9 performs well as a screening instrument, but in diagnosing depressive disorder, a formal diagnostic process following the PHQ-9 remains imperative. The PHQ-9 does not seem adequate for measuring severity

Zuithoff,N.P., et al (2009). A clinical prediction rule for detecting major depressive disorder in primary care: the PREDICT-NL study. *Family Practice* 26(4), 241-250.

<http://dx.doi.org/10.1093/fampra/cmp036>

<http://pmid.us/19546117>

Background: Major depressive disorder often remains unrecognized in primary care. Objective: Development of a clinical prediction rule using easily obtainable predictors for major depressive disorder in primary care patients. MethodS: A total of 1046 subjects, aged 18-65 years, were included from seven large general practices in the center of The Netherlands. All subjects were recruited in the general practice waiting room, irrespective of their presenting complaint. Major depressive disorder according to Diagnostic and Statistical Manual of Mental Disorders, Fourth Text Revision edition criteria was assessed with the Composite International Diagnostic Interview. Candidate predictors were gender, age, educational level, being single, number of presented complaints, presence of non-somatic complaints, whether a diagnosis was assigned, consultation rate in past 12 months, presentation of depressive complaints or prescription of antidepressants in past 12 months, number of life events in past 6 months and any history of depression. Results: The first multivariable logistic regression model including only predictors that require no confronting depression-related questions had a reasonable degree of discrimination (area under the receiver operating characteristic curve or concordance-statistic (c-statistic) = 0.71; 95% Confidence Interval (CI): 0.67-0.76). Addition of three simple though more depression-related predictors, number of life events and history of depression, significantly increased the c-statistic to 0.80 (95% CI: 0.76-0.83). After transforming this second model to an easily to use risk score, the lowest risk category (sum score < 5) showed a 1% risk of depression, which increased to 49% in the highest category (sum score > or = 30). Conclusion: A clinical prediction rule allows GPs to identify patients-irrespective of their complaints-in whom diagnostic workup for major depressive disorder is indicated

PATIENT AND PUBLIC INVOLVEMENT

Adamson, J., et al (2009). Exploring the impact of patient views on 'appropriate' use of services and help seeking: a mixed method study. *British Journal of General Practice* 59 (564), e226-e233.

<http://dx.doi.org/10.3399/bjgp09X453530>

<http://pmid.us/19566989>

Background: There are commonly-held views relating to what constitutes appropriate and inappropriate use of finite NHS resources. However, very little is known about how and why such views have an impact on consultation patterns. Aim: To quantify the prevalence of opinion on whether people use health services unnecessarily within primary care and accident and emergency (A&E) in order to examine the impact of these views on help-seeking behaviour. Design of study: A mixed method study utilising cross-sectional questionnaire survey and semi-structured interviews. Setting: A primary care practice in South West England, UK. Method: Responders to the questionnaire survey were drawn from a random sample of individuals, stratified by sex, selected from one practice in the UK (n = 911). The qualitative sample (n = 22) were purposefully selected from the same general practice. Results: The quantitative data suggest that the majority of people believe individuals utilise either GP or A&E services inappropriately (65.6%; 95% confidence interval [CI] = 62.4 to 68.7). However, strong views relating to this inappropriate healthcare use were not associated with reported seeking of immediate care (odds ratio [OR] = 0.98, 95% CI = 0.66 to 1.46 for 'lump' vignette). Responders tend to consider other people as time wasters, but not themselves. Individuals' generally describe clear rationales for help seeking, even for seemingly trivial symptoms and anxiety level was strongly predictive of health-seeking behaviour (OR = 2.88; 95% CI = 1.98 to 4.19 for lump vignette). Conclusion: Perceptions that individuals' use health services inappropriately are unlikely to explain differences in help-seeking behaviours. The findings suggest that people do not take the decision to consult health services lightly and rationalise why their behaviour is not time wasting

Heisler, M., (2009). Physicians participatory decision-making and quality of diabetes care processes and outcomes: results from the triad study. *Chronic Illness* Epub ahead of print 12/08/2009

<http://dx.doi.org/10.1177/1742395309339258>

<http://pmid.us/19675116>

Objectives: In participatory decision-making (PDM), physicians actively engage patients in treatment and other care decisions. Patients who report that their physicians engage in PDM have better disease self-management and health outcomes. We examined whether physicians' diabetes-specific treatment PDM preferences as well as their self-reported practices are associated with the quality of diabetes care their patients receive. Methods: 2003 cross-sectional survey and medical record review of a random sample of diabetes

patients (n = 4198) in 10 US health plans across the country and their physicians (n = 1217). We characterized physicians' diabetes care PDM preferences and practices as no patient involvement,' physician-dominant,' shared,' or patient-dominant' and conducted multivariate analyses examining their effects on the following: (1) three diabetes care processes (annual hemoglobin A1c test; lipid test; and dilated retinal exam); (2) patients'satisfaction with physician communication; and (3) whether patients' A1c, systolic blood pressure (SBP), and low-density lipoprotein cholesterol (LDL) were in control.Results: Most physicians preferred shared' PDM (58%) rather than no patient involvement' (9%), physician-dominant' (28%) or patient dominant' PDM (5%). However, most reported practicing physician-dominant' PDM (43%) with most of their patients, rather than no patient involvement' (13%), shared' (37%) or patient-dominant' PDM (7%). After adjusting for patient and physician-level characteristics and clustering by health plan, patients of physicians who preferred shared' PDM were more likely to receive A1c tests [90% vs. 82%, AOR: 2.05, 95% CI: 1.03-3.07] and patients of physicians who preferred patient-dominant' treatment decision-making were more likely to receive lipid tests [60% vs. 50%, AOR: 1.58, 95% CI: 1.04-2.39] than those of providers who preferred no patient involvement' in treatment decision-making. There were no differences in patients' satisfaction with their doctor's communication or control of A1c, SBP or LDL depending on their physicians' PDM preferences. Physicians' self-reported PDM practices were not associated with any of the examined aspects of diabetes care in multivariate analyses.Conclusions: Patients whose physicians prefer more patient involvement in decision-making are more likely than patients whose physicians prefer more physician-directed styles to receive some recommended risk factor screening tests, an important first step toward improved diabetes outcomes. Involving patients in treatment decision-making alone, however, appears not to be sufficient to improve biomedical outcomes

Learmonth,M., Martin,G.P., & Warwick,P. (2009). Ordinary and effective: the Catch-22 in managing the public voice in health care? *Health Expectations* 12(1), 106-115.

<http://dx.doi.org/10.1111/j.1369-7625.2008.00529.x>

<http://pmid.us/19250156>

Introduction: Joseph Heller's Catch-22 is regularly invoked to critique the irrationality inherent in supposedly rational bureaucracy. We explore a Catch-22 for policy concerning public involvement in English health care: you have to be ordinary to represent the community effectively, but, if you are ordinary, you cannot effectively represent your community. The nature of public participation groups: Starting with community health councils, we trace government policy about involving local people in health care, up to the current arrangements for local involvement networks and show how the above Catch-22 works. We do this in two principal ways. First, by an analysis of some of the unrecognized paradoxes in current government policies designed to populate health-care participation groups and second, by providing a series of narrative vignettes, drawn from our own experiences of working in such groups, which illustrate the nature of the dilemmas members face. Conclusions: Our proposal to get out of the worst of the

Catch-22 for effective public involvement groups is (paradoxically) to suggest focusing less on effectiveness, or more precisely, focusing less on those conventional, managerially defined notions of effectiveness that are now pretty much taken for granted within public services. This is because, if bodies like LINKs are to do more than provide unthreatening, homogenous and tokenistic public perspectives, they need to be given space and time to pursue their own agendas

Mitton,C., et al (2009). Public participation in health care priority setting: A scoping review. *Health Policy*, 91(3), 219-228.

<http://dx.doi.org/10.1016/j.healthpol.2009.01.005>

<http://pmid.us/19261347>

Objective: While much literature has debated public engagement in health care decision-making, there is no consensus on when public engagement should be sought and how it should be obtained. We conducted a scoping review to examine public engagement in one specific area: priority setting and resource allocation. Method: The review drew upon a broad range of health and non-health literature in an attempt to elicit what is known and not known on this topic, and through this to outline any guidance to assist decision-makers and identify where efforts for future research should be directed. Results: Governments appear to recognize benefits in consulting multiple publics using a range of methods, though more traditional approaches to engagement continue to predominate. There appears to be growing interest in deliberative approaches to public engagement, which are more commonly on-going rather than one-off and more apt to involve face-to-face contact. However, formal evaluation of public engagement efforts is rare. Also absent is any real effort to demonstrate how public views might be integrated with other decision inputs when allocating social resources. Conclusion: While some strands can be taken to inform current priority setting activity, this scoping review identified many gaps and highlights numerous areas for further research

Pawlikowska,T.R., et al (2009). Patient involvement in assessing consultation quality: a quantitative study of the Patient Enablement Instrument in Poland. *Health Expectations* Epub ahead of print 28/08/2009

<http://dx.doi.org/10.1111/j.1369-7625.2009.00554.x>

<http://pmid.us/19719536>

Background Promoting a more patient-responsive service has been the focus of policy initiatives in newer EU states. One measure of success should be the patient's assessment of their consultation with their doctor. Objectives To measure consultation quality in Polish primary care using patient enablement (a patient-driven instrument developed in the UK) and to test its theoretical framework. To compare the patient enablement outcome of different types of doctor delivering primary care in Poland following reform. Design Cross-sectional quantitative questionnaire survey. Setting Random sample of primary care doctors practising within a 60-km radius of Gdansk, Poland. Subjects and

outcome measures Patient Enablement Instrument and correlates were measured in 7924 consecutive adult consultations of 48 doctors, stratified according to training: family medicine specialists (diploma holders), non-diplomates and general medicine doctors (polyclinic internists). Results Completion was high (78%). The mean patient enablement score in Poland was 4.0 (SD 3.3) and mean consultation length was 10.3 min (SD 5.4 min). Consultation length and knowing the doctor are independently related to patient enablement in the Polish context. Variation between doctors is significant, but earlier differences in enablement between alternative providers have largely been ameliorated in practice. Conclusion It is feasible to use patient enablement on a large scale at routine consultation in primary care in Poland: acceptability was good in diverse environments. The internal consistency of enablement and its relationships broadly mirror those found in the UK. The effect of patient expectations shaped by social and cultural issues influencing enablement outcome requires further investigation

Smith,E., et al (2009). Getting ready for user involvement in a systematic review. *Health Expectations*, 12(2), 197-208.

<http://dx.doi.org/10.1111/j.1369-7625.2009.00535.x>

<http://pmid.us/19236632>

Objective: This paper aims to support the critical development of user involvement in systematic reviews by explaining some of the theoretical, ethical and practical issues entailed in 'getting ready' for user involvement. BACKGROUND: Relatively few health or social care systematic reviews have actively involved service users. Evidence from other research contexts shows that user involvement can have benefits in terms of improved quality and outcomes, hence there is a need to test out different approaches in order to realize the benefits of user involvement and gain a greater understanding of any negative outcomes. Design: Setting up a service-user reference group for a review of user involvement in nursing, midwifery and health visiting research involved conceptualizing user involvement, developing a representation framework, identifying and targeting service users and creating a sense of mutuality and reciprocity. Setting and participants: Recruitment was undertaken across England by two researchers. Members from 24 national consumer organizations were selected to participate in the review. Main variables studied: Learning was gained about finding ways of navigating consumer networks and organizations, how best to communicate our goals and intentions and how to manage selection and 'rejection' in circumstances where we had stimulated enthusiasm. Results and conclusions: Involving service users helped us to access information, locate the findings in issues that are important to service users and to disseminate findings. User involvement is about relationships in social contexts: decisions made at the early conceptual level of research design affect service users and researchers in complex and personal ways

Thompson,J., et al (2009). Health researchers' attitudes towards public involvement in health research. *Health Expectations.*, 12(2), 209-220

<http://dx.doi.org/10.1111/j.1369-7625.2009.00532.x>

<http://pmid.us/19392833>

Objective: To investigate health researchers' attitudes to involving the public in research. Background: Public involvement in research is encouraged by the Department of Health in the UK. Despite this, the number of health researchers actively involving the public in research appears to be limited. There is little research specifically addressing the attitudes of health researchers towards involving the public: how they interpret the policy, what motivates and de-motivates them and what their experiences have been to date. DESIGN: A qualitative research design, using semi-structured telephone interviews. Setting and participants: Fifteen purposively sampled UK-based University health researchers were the participants. Interviews were conducted over the telephone. Findings: The participants suggested varying constructions of public involvement in research. Arguments based on moral and political principles and consequentialist arguments for involving the public in research were offered and most participants highlighted the potential benefits of involving the public. However, feelings of apprehension expressed by some participants imply that a number of researchers may still be uncomfortable with involving the public, as it presents a different way of working

van de Bovenkamp,H.M., Trappenburg,M.J., & Grit,K.J. (2009). Patient participation in collective healthcare decision making: the Dutch model. *Health Expectations* Epub ahead of print 28/08/2009

<http://dx.doi.org/10.1111/j.1369-7625.2009.00567.x>

<http://pmid.us/19719537>

Objective To study whether the Dutch participation model is a good model of participation. Background Patient participation is on the agenda, both on the individual and the collective level. In this study, we focus on the latter by looking at the Dutch model in which patient organizations are involved in many formal decision-making processes. This model can be described as neo-corporatist. Design We did 52 interviews with actors in the healthcare field, 35 of which were interviews with representatives of patient organizations and 17 with actors that involved patient organizations in their decision making. Results Dutch patient organizations have many opportunities to participate in formal healthcare decision making and, as a result, have become institutionalized. Although there were several examples identified in which patient organizations were able to influence decision making, patient organizations remain in a dependent position, which they try to overcome through professionalization. Discussion Although this model of participation gives patient organizations many opportunities to participate, it also causes important tensions. Many organizations cannot cope with all the participation possibilities attributed to them. This participation abundance can therefore cause redistribution effects. Furthermore, their dependent position leads to the danger of being put to instrumental use. Moreover, professionalization causes tensions concerning empowerment possibilities and representativeness. Conclusion Although the Dutch

model tries to make patient organizations an equal party in healthcare decision making, this goal is not reached in practice. It is therefore important to study more closely which subjects patients can and should contribute to, and in what way

PRIMARY/SECONDARY CARE INTERFACE

Berendsen,A., et al (2009). How do general practitioners and specialists value their mutual communication? A survey. *BMC Health Services Research*, 9(1), 143. 8th August 2009

<http://dx.doi.org/10.1186/1472-6963-9-143>

<http://www.biomedcentral.com/1472-6963/9/143/abstract>

<http://pmid.us/19664238>

Background: Communication between general practitioners (GPs) and specialists is important, if we want patients to receive the right type of care at the right moment. Most communication takes place through telephone contact, letters concerning information on patients more recently also by email, and joint postgraduate training. As much research has been aimed at the content of communication between GPs and specialists, we wished to address the procedural aspects of this communication. We addressed the following research question. How do GPs and specialists assess their mutual communication through telephone, letters and postgraduate courses? Methods:A cross-sectional study was conducted among a random sample of 550 GPs and 533 specialists selected from the Netherlands Medical Address Book. The response rate was 47% GPs (n=259) and 44% specialists (n=232).Results: Specialists qualify the GPs' telephone accessibility as poor; while GPs themselves do not. Specialists think poorly of the GPs' referral letter. Merely half of GPs feels their questions are addressed appropriately by the specialist, whereas specialists think this number is considerably higher. According to specialists, GPs often do not follow the advice given by them. GPs rate their compliance much higher. Less than a quarter of GPs feel the specialist's letter arrives on time. Specialists have a different perception of this. Both parties wish to receive feedback from one and other, while in practice they do so very little. Conclusions: GPs and specialists disagree on several aspects of their communication. This impedes improvements. Both GP's accessibility by phone and time span to the specialist's report could be earmarked as performance indicators. GPs and specialists should discuss amongst themselves how best to compose a format for the referral letter and the specialist's report and how to go about exchanging mutual feedback

Berendsen,A.J., et al (2009). Patient's need for choice and information across the interface between primary and secondary care: A survey. *Patient Education and Counseling* Epub ahead of print 25/08/2009

<http://dx.doi.org/10.1016/j.pec.2009.07.032>

<http://pmid.us/19713065>

Objective: Hospitals in the Netherlands have recently made certain performance data public, allowing patients to choose the location of their care. The objective of this study is to assess (a) patient preferences and experiences concerning the transition between primary and secondary health care, (b) patients' needs for choice and information and how these are influenced by personal and morbidity factors. Methods: Two different types of questionnaires were used. The first questionnaire concerns the importance that patients attach to the care provided. The second questionnaire concerns the actual experiences of the patient with the care provided. For the selection of patients, we used the databases of the registration networks of the Departments of General Practice of the Universities of Groningen and Leiden. The questionnaires were returned by 513 patients (Importance 69%) and 1404 patients (Experience 65%). Results: Many patients prefer the GP advising them regarding which hospital or specialist they should be referred to: a quarter of the patients preferred that the GP decided for them. Patients with a curable condition and patients aged between 25 and 65, highly educated and with stable personal characteristics as measured by a purposive scale, more often wished to use information from internet or newspapers to make a decision. The amount of information that was needed on illness or treatment varied greatly. Young people, older people, and those with less stable personal characteristics more often desired only practical information. Conclusions: In spite of making performance data of different health care institutions public, only a limited number of patients want to use this information on a limited number of health problems. Practice implications: Care providers should take differences into account concerning patients' need for information on their illness

Bjertnaes,O.A. et al . (2009). The association between GP and patient ratings of quality of care at outpatient clinics. *Family Practice* Epub ahead of print 7/07/2009

<http://dx.doi.org/10.1093/fampra/cmp043>

<http://pmid.us/19584122>

Background: GPs and patients are frequently asked to evaluate mental health care, but studies including evaluations from both groups are rare. Objective: To assess the association between GPs' and patients' assessment of mental health outpatient clinic in

Norway and identify important health care predictors for patient and GP satisfaction with the clinics. Methods: Two cross-sectional national surveys were carried out: survey of GPs in 2006 and patients in 2007 evaluating outpatient clinics at 69 community mental health centres in Norway. A total of 2009 GPs and 9001 outpatients assessed the clinics by means of a postal questionnaire. Main outcome measures were correlations between GP and patient ratings of the outpatient clinics at the clinic level and health care predictors for patient satisfaction and GP satisfaction with the clinics. Results: Clinic scores for GPs' and patients' assessment of waiting time were moderate to highly correlated (0.65), while clinic scores for GP and patient satisfaction had a lower but significant positive association (0.37). Significant positive correlations between clinic scores for GP and patients ratings were found for 38 of the 48 associations tested. The most important predictors for patient satisfaction with the clinics were interaction with the clinician (beta: 0.23) and being met with politeness and respect at the clinic (beta: 0.19), while the most important predictors for GP satisfaction with the clinics were perceived competence (beta: 0.25), rejection of referrals (beta: -0.17) and waiting time for patients (beta: -0.16). Conclusions: A consistent positive association between GP and patient ratings at the clinic level was identified. Mental health services aiming at improving GP and patient satisfaction should be sensitive to the fact that the two groups prioritize different health care factors

QUALITY

Campbell,S.M., et al (2009). Effects of pay for performance on the quality of primary care in England. *New England Journal of Medicine* 361(4), 368-378.

<http://dx.doi.org/10.1056/NEJMsa0807651>

<http://pmid.us/19625717>

Background: A pay-for-performance scheme based on meeting targets for the quality of clinical care was introduced to family practice in England in 2004. Methods: We conducted an interrupted time-series analysis of the quality of care in 42 representative family practices, with data collected at two time points before implementation of the scheme (1998 and 2003) and at two time points after implementation (2005 and 2007). At each time point, data on the care of patients with asthma, diabetes, or coronary heart disease were extracted from medical records; data on patients' perceptions of access to care, continuity of care, and interpersonal aspects of care were collected from questionnaires. The analysis included aspects of care that were and those that were not associated with incentives. Results: Between 2003 and 2005, the rate of improvement in the quality of care increased for asthma and diabetes ($P < 0.001$) but not for heart disease. By 2007, the rate of improvement had slowed for all three conditions ($P < 0.001$), and the quality of those aspects of care that were not associated with an incentive had declined for patients with asthma or heart disease. As compared with the period before the pay-for-performance scheme was introduced, the improvement rate after 2005 was unchanged

for asthma or diabetes and was reduced for heart disease ($P=0.02$). No significant changes were seen in patients' reports on access to care or on interpersonal aspects of care. The level of the continuity of care, which had been constant, showed a reduction immediately after the introduction of the pay-for-performance scheme ($P<0.001$) and then continued at that reduced level. Conclusions: Against a background of increases in the quality of care before the pay-for-performance scheme was introduced, the scheme accelerated improvements in quality for two of three chronic conditions in the short term. However, once targets were reached, the improvement in the quality of care for patients with these conditions slowed, and the quality of care declined for two conditions that had not been linked to incentives. Continuity of care was reduced after the introduction of the scheme

DeVoe, J.E., Wallace, L.S., & Fryer, G.E., Jr. (2009). Measuring patients' perceptions of communication with healthcare providers: do differences in demographic and socioeconomic characteristics matter? *Health Expectations* 12(1), 70-80.

<http://dx.doi.org/10.1111/j.1369-7625.2008.00516.x>

<http://pmid.us/19250153>

Background: National governments across the globe have set goals to improve healthcare delivery. Understanding patient-provider communication is essential for the development of policies that measure how well a healthcare system delivers care. Objectives: This study was designed to determine which, if any, demographic factors were independently associated with how US patients perceive various aspects of communication with their healthcare providers. Design and methods: The study was a secondary, cross-sectional analysis of nationally representative data from the 2002 Medical Expenditure Panel Survey (MEPS). Among US adults with a healthcare visit in the past year ($n =$ approximately 16,700), we assessed the association between several covariate demographic and socioeconomic factors and four dependent measures of patient perceptions of communication with their healthcare providers. Results: Across all four measures of communication, older patients were more likely to report positively. Having health insurance and a usual source of care were consistent predictors of positive perceptions of communication. Hispanic patients also reported better perceptions of communication across all four measures. The most economically disadvantaged patients were less likely to report that providers always explained things so that they understood. Male patients were more likely to report that providers always spent enough time with them. Conclusions: This study suggests that patient perceptions of communication in healthcare settings vary widely by demographics and other individual patient characteristics. In this paper, we discuss the relevance of these communication disparities to design policies to improve healthcare systems, both at the individual practice level and the national level

Hiscock,J., et al (2009). Complexity in simple tasks: a qualitative analysis of GPs 'completion of long-term incapacity forms. *Primary Health Care Research & Development*, 10(03), 254-269.

<http://dx.doi.org/10.1017/S1463423609001236>

Aim To explore the factors influencing the completion of the IB113 form for the Department for Work and Pensions (DWP), as an exemplar of how general practitioners (GPs) manage and report patient information to external bodies. Background In UK, GPs complete IB113 forms for their patients approaching longer-term sickness absence, who may be exempt from the incapacity benefit linked medical examination. The DWP has expressed concerns about the quality of such reports, and GP organizations have raised objections to completing such forms. The content of returned forms is variable, and may be subject to a number of influences. Design Qualitative interviews with purposive sampling of GPs and practice managers (PMs). Setting Primary Care practices in the North East of England .Method GPs and PMs were interviewed using a semi-structured topic guide about completing IB113 forms for the DWP about their patients entering long-term incapacity. The transcribed data were analysed thematically using the framework analysis method. Results Whilst the IB113 appears superficially straightforward to complete, our results demonstrate levels of overlapping complexity that add ranges of subjectivity and selectivity onto factual reporting, including practice protocols, the gathering and managing of information, the doctors personal views on systems. Conclusions The recording and reporting of patient related data by GPs is subject to complex influences, which need to be understood and managed to improve the relevance and quality of reports to third parties

Kringos,D.S., Boerma,W., & Pellny,M. (2009). Measuring mechanisms for quality assurance in primary care systems in transition: test of a new instrument in Slovenia and Uzbekistan. *Quality in Primary Care* 17(3), 165-177.

<http://pmid.us/19622267>

Background: This World Health Organization (WHO) study aimed to develop and field test an instrument to assess the availability of structures and mechanisms for managing quality in primary care in countries in transition. Method: The instrument is based on a literature study, consensus meetings with experts, and observations in these countries. It consists of three parts: a semi-structured questionnaire on national policies and mechanisms; a structured questionnaire for general practitioners (GPs); and a structured questionnaire for use with managers of primary care facilities. The instrument has been field tested in 2007 in Slovenia and Uzbekistan. Results: In Slovenia, leadership on quality improvement was weak and local managers reported few incentives and resources to control quality. There was a lack of external support for quality improvement activities. Availability and use of clinical guidelines for GPs were not optimal. GPs found teamwork and communication with patients inadequate. In Uzbekistan, primary care quality and standards in health centres were extensively regulated and laid down in numerous manuals, instructions and other documents. Managers, however, indicated the need for more financial and non-financial levers for quality improvement and they

wanted to know more about modern healthcare management. GPs reported strong involvement in activities such as peer review and clinical audit, and reported frequent use of clinical guidelines. Overall, the information gathered with the provisional instrument has resulted in policy recommendations. At the same time, the pilot resulted in improvements to the instrument. Conclusion: Application of the instrument helps decision makers to identify improvement areas in the infrastructure for managing the quality of primary care

Sturmborg, J.P., et al (2009). Identifying patterns in primary care consultations: a cluster analysis. *Journal of Evaluation in Clinical Practice* 15(3), 558-564.

<http://dx.doi.org/10.1111/j.1365-2753.2009.01167.x>

<http://pmid.us/19522911>

Background: A literature review revealed that little is known about the systems context of general practice consultations and their outcomes. Objectives: To describe the systems context and resulting underlying patterns of primary care consultations in a local area. Design: Cross-sectional multi-practice study based on a three-part questionnaire. Cluster analysis of data. Setting: Stratified random sample of general practices and general practitioners--NSW-Central Coast, Australia. Participants: A total of 1104 adults attending 12 general practitioners between February and November 1999. Results and conclusions: The study identified seven subgroups within the study population uniquely defined by variables from the health system, individual doctor and patient, consultation and consultation outcomes domains. A systems approach provides a framework in which to track and consider the important variables and their known and/or expected workings and thus offer a contextual framework to guide primary care reform

van den, Hombergh P., et al (2009). High workload and job stress are associated with lower practice performance in general practice: an observational study in 239 general practices in the Netherlands. *BMC Health Services Research* , 9 118.

<http://dx.doi.org/10.1186/1472-6963-9-118>

<http://www.biomedcentral.com/1472-6963/9/118>

<http://pmid.us/19604386>

Background: The impact of high physician workload and job stress on quality and outcomes of healthcare delivery is not clear. Our study explored whether high workload and job stress were associated with lower performance in general practices in the Netherlands. Methods: Secondary analysis of data from 239 general practices, collected in practice visits between 2003 to 2006 in the Netherlands using a comprehensive set of measures of practice management. Data were collected by a practice visitor, a trained non-physician observer using patients questionnaires, doctors and staff. For this study we selected five measures of practice performance as outcomes and six measures of GP workload and job stress as predictors. A total of 79 indicators were used out of the 303

available indicators. Random coefficient regression models were applied to examine associations. Results and discussion: Workload and job stress are associated with practice performance. Workload: Working more hours as a GP was associated with more positive patient experiences of accessibility and availability ($b = 0.16$). After list size adjustment, practices with more GP-time per patient scored higher on GP care ($b = 0.45$). When GPs provided more than 20 hours per week per 1000 patients, patients scored over 80% on the Europep questionnaire for quality of GP care. Job stress: High GP job stress was associated with lower accessibility and availability ($b = 0.21$) and insufficient practice management ($b = 0.25$). Higher GP commitment and more satisfaction with the job was associated with more prevention and disease management ($b = 0.35$). Conclusion: Providing more time in the practice, and more time per patient and experiencing less job stress are all associated with perceptions by patients of better care and better practice performance. Workload and job stress should be assessed by using list size adjusted data in order to realise better quality of care. Organisational development using this kind of data feedback could benefit both patients and GP

Varkey,P., et al (2009). Using quality-improvement techniques to enhance patient education and counselling of diagnosis and management. *Quality in Primary Care*, 17(3), 205-213.

<http://pmid.us/19622271>

Background: Patients recall less than half the information provided to them by their physicians. Aims: The aim of this study was to use quality-improvement (QI) techniques to enhance patient understanding of diagnosis, management and follow-up at the end of the office visit. Method: QI techniques including stakeholder analysis, process mapping and plan-do-study-act (PDSA) cycles were used in a pilot study in an outpatient endocrinology clinic specialising in bone disease. The impact of these interventions was evaluated by pre- and post-intervention patient surveys that included qualitative and quantitative data. Results: A team of endocrinology fellows and faculty with expertise in QI developed a series of tools to encourage conversation and interaction during the encounter and to serve as a reference for patients to take home through five PDSA cycles. The tools were iterations of written materials provided to patients at the end of the clinical encounter. In each cycle, the tools were modified according to feedback from patients and providers. Ninety-three patients participated in this study. Patients were surveyed after the implementation of two of the five cycles. Compared with pre-intervention, modifications during the two cycles were associated with a non-significant increase in patients' understanding of the reasons for testing (from 64% to 80% and 75%); management plan (from 61% to 86% and 79%); and future follow-up plans (from 64% to 86% and 81%); $P > 0.05$ for all three outcomes. Improvement was not seen in patients' knowledge of their diagnoses (from 74% to 73% and 70%; $P > 0.05$). Conclusion: This pilot study shows how QI tools can be used for creating and initiating system improvements aimed at enhancing patient education and counselling

Watson,P.W., & McKinstry,B. (2009). A systematic review of interventions to improve recall of medical advice in healthcare consultations. *Journal of the Royal Society of Medicine* 102(6), 235-243.

<http://dx.doi.org/10.1258/jrsm.2009.090013>

<http://pmid.us/19531618>

Background: In order for patients to adhere to healthcare advice, it is essential that they are able to recall this following a consultation. Although psychological research exists which highlights techniques and factors postulated to influence recall, only a limited body of work has been conducted to evaluate their effectiveness in a clinical context. AIM: To carry out a systematic review of intervention trials designed to enhance recall of medical information. Methods: We searched Medline (1950-April 2007); Embase (1980-April 2007); Cinahl (1982-April 2007); PsychINFO (1969-2007); and the Cochrane Library Collection. Secondary searches were made through reference to relevant journals and reference lists from relevant papers/review papers. Results: From 69 papers provisionally identified, 34 papers met the inclusion criteria. Nine recall interventions had been evaluated (audio recordings, written materials, adjunct questions, prompt sheets, visual aids, cognitive strategies, rehearsal, communication styles and personalized teaching). Despite the experimental and theoretical evidence which could have informed cognitive interventions to enhance recall of healthcare advice, most studies primarily focused on the use of written and/or audio-recorded medical instructions. Although the majority of studies supported these approaches insofar as they enhanced recall, the findings were equivocal. Conclusion: While written and tape-recorded instructions appear to improve recall in most situations, a dearth of interventions incorporating psychological theory was readily apparent. Further research is required in clinical settings to determine if cognitive interventions based on a more over-arching psychological model of recall are effective

RESEARCH AND DEVELOPMENT

Bambra,C. (2009). Fear of the Dark? A beginner's guide to undertaking systematic reviews of public health policy interventions. *Journal of Epidemiology and Community Health* Epub ahead of print 25/08/2009

<http://dx.doi.org/10.1136/jech.2009.088740>

<http://pmid.us/19710043>

Background: The systematic review is becoming an increasingly popular and established research method in public health. It is now widely considered within policy and practice circles to be a good way of making research evidence accessible and useable. Obtaining systematic review skills are therefore becoming a common requirement for most public health researchers and practitioners. However, most researchers still remain apprehensive and fearful about conducting their first systematic review. This is often because an "ideal" type of systematic review is promoted in the systematic review methods literature. Methods: Drawing upon an extensive practical experience of conducting various types of systematic reviews of complex social interventions in the field of public health policy, this brief guide is intended to help dispel these concerns by providing an accessible overview for novices of a "real" approach to conducting systematic reviews. Results: It discusses what a systematic review is and how definitions vary. It describes the stages of a review in simple terms. It then outlines five "do's and don'ts" of the method in practice outlining debates and potential ways to save time and resources. Conclusion: It concludes with a reflection on the flexibility and value of the method

Bower,P., et al (2009). Improving recruitment to health research in primary care. *Family Practice* Online 23/6/2009

<http://dx.doi.org/10.1093/fampra/cmp037>

<http://pmid.us/19549623>

Background: Recruitment to health research is known to be problematic. However, evidence concerning ways of improving recruitment is sparse. Objective: To outline the process of recruitment, factors impacting on recruitment success and key areas for further research and development. Methods: Narrative literature review. Results: This paper argues that three ways of improving recruitment should form the focus of future work: developing a repository of evidence-based techniques and methods which can be introduced by research teams; developing the infrastructure to support recruitment, especially new technologies around the electronic patient record; and increasing public engagement with research, to improve participation by both clinicians and patients. Conclusion: Recruitment to health research in primary care remains a major hurdle, and key research and development priorities must be addressed

Campbell,J., et al (2009). The GP Patient Survey for use in primary care in the National Health Service in the UK - development and psychometric characteristics. *BMC Family Practice* 10(1), 57

<http://dx.doi.org/10.1186/1471-2296-10-57>

<http://www.biomedcentral.com/1471-2296/10/57/abstract>

<http://pmid.us/19698140>

Background: The UK National GP Patient Survey is one of the largest ever survey programmes of patients registered to receive primary health care, inviting five million respondents to report their experience of NHS primary healthcare. The third such annual survey (2008/9) involved the development of a new survey instrument. We describe the process of that development, and the findings of an extensive pilot survey in UK primary healthcare. Method: The survey was developed following recognised guidelines and involved expert and stakeholder advice, cognitive testing of early versions of the survey instrument, and piloting of the questionnaire in a cross sectional pilot survey of 1,500 randomly selected individuals from the UK electoral register with two reminders to non-respondents. Results: The questionnaire comprises 66 items addressing a range of aspects of UK primary healthcare. A response rate of 590/1500 (39.3%) was obtained. Non response to individual items ranged from 0.8% to 15.3% (median 5.2%). Participants did not always follow internal branching instructions in the questionnaire although electronic controls allow for correction of this problem in analysis. There was marked skew in the distribution of responses to a number of items indicating an overall favourable impression of care. Principal components analysis of 23 items offering evaluation of various aspects of primary care identified three components (relating to doctor or nurse care, or addressing access to care) accounting for 68.3% of the variance in the sample. Conclusion: The GP Patient Survey has been carefully developed and pilot-tested. Survey findings, aggregated at practice level, will be used to inform the distribution of GBP65 million (\$107 million) of UK NHS resource in 2008/9 and this offers the opportunity for NHS service planners and providers to take account of users' experiences of health care in planning and delivering primary healthcare in the UK

Carr,S. (2009). Leadership for health improvement--implementation and evaluation. *Journal of Health Organization and Management*, 23(2), 200-215.

<http://pmid.us/19711778>

Purpose: The purpose of this paper is to present a co-authored reflection on the health improvement leadership development programme and the key evaluation messages derived from piloting in an English National Health Service region. It highlights the specific attributes of this approach to health improvement leadership development and clarifies health improvement development issues. Design /Methodology/Approach: Appreciative inquiry and soft systems methodology are combined in an evaluation approach designed to capture individual as well as organisation learning and how it impacts on leadership in specific contexts. Findings: The evaluation exposes the health improvement leadership needs of a multi-organisation cohort, offers some explanations for successful achievement of learning needs while also exposing of the challenges and paradoxes faced in this endeavour. Originality/Value: There are limited reported templates of how to develop leadership for health improvement. This paper details a whole systems approach, acknowledging the impact of context on leadership and an approach to evaluating such complex initiatives

Haller,D.M et al (2009). Text message communication in primary care research: a randomized controlled trial. *Family Practice* 26(4), 325-330.

<http://dx.doi.org/10.1093/fampra/cmp040>

<http://pmid.us/19542193>

Background: Text message communication is increasingly used in clinical practice but rarely in research. Particularly in young people, this method of participation in primary care research appears both feasible and acceptable. However, previous experience shows that text messaging for research may lead to lower response rates. Aim. To test the hypothesis that text message communication in primary care research does not lead to lower response rates compared to a paper-based method. Methods: This randomized controlled trial took place in 26 randomly selected practices in Victoria, Australia. Consecutive patients aged 16-24 years attending general practice appointments were recruited as part of a larger study on patients' perspectives. Patients owning a mobile phone were randomized to receive a question about satisfaction with the consultation either by text message or on a card completed before leaving the practice. Logistic regression was used to estimate the effect on the response rate of using text message rather than the card method, adjusting for clustering within practices and for differences in baseline characteristics among participants. Results: In total, 402 of 409 eligible young people agreed to participate and were randomized to either receive a text message (n = 193) or a card enquiry (n = 209). The response rate was 80.2% [95% confidence interval (CI): 73.3-87.1%] with text message and 85.6% (95% CI: 79.6-91.7%) with the card. The adjusted odds of responding (odds ratio: 0.62; 95% CI: 0.30-1.27) were not significantly lower in the group using text messaging compared to the group using the card response method. Conclusion: These findings offer new perspectives for use of text message communication to gather information from patients in primary care research

Ives,J., et al . (2009). Do family doctors have an obligation to facilitate research? *Family Practice* Epub ahead of print 9/07/2009

<http://dx.doi.org/10.1093/fampra/cmp045>

<http://pmid.us/19589883>

In the third of a series of articles examining ethical issues in primary care research, we argue that family doctors, when considering what they ought to do in relation to research, have a positive obligation to participate in research and that one means of discharging this obligation is to collaborate in research studies by aiding recruitment. We offer three arguments in support of this obligation-arguments from fairness, reason and utility. We then go on to specify a series of conditions on this obligation which take into account that doctors have many other obligations. These are the conditions of financial remuneration, reciprocity and ability

McKevitt,C., Fudge,N., & Wolfe,C. (2009). What is involvement in research and what does it achieve? Reflections on a pilot study of the personal costs of stroke. *Health Expectations* Epub ahead of print 19/08/2009

<http://dx.doi.org/10.1111/j.1369-7625.2009.00573.x>

<http://pmid.us/19691463>

Background Health researchers are encouraged to involve service users as partners in their research. There is a need to increase the evidence base of involvement, including an accumulation of empirical accounts of involvement practices, demonstrating how involvement influences research and refinement of the concept itself. Aims To report the development of a pilot study by academic researchers and stroke service users belonging to a user research group to investigate costs of stroke to individuals and families; to reflect on what this example of user involvement achieved and implications for what involvement means. Methods We conducted a 2-year ethnographic study that included participant observation, formal and informal interviews with professionals and user group members and documentary analysis. Data were systematically recorded to permit description of processes and reflexive analysis. Results and conclusions We report on five stages of the research process from service user identification of a research question to interpretation of pilot study findings. Professional researchers led the research process and developed a novel method to involve stroke service users in the development of a questionnaire. Some academic colleagues questioned the value of the proposed investigation as it did not appear to conform to implicit criteria of quality research. We argue that the moral status that user involvement has acquired means that academics' concerns about quality did not prevent the pilot study from being conducted. We suggest that much of what was undertaken might be considered standard good practice in developing new research studies but also identify additional benefits of user involvement. Implications for conceptual development and evaluation are discussed

Richards, S.H. et al 2009. A multi-method analysis of free-text comments from the UK General Medical Council Colleague Questionnaires. *Medical Education* 43(8), 757-766.

<http://dx.doi.org/10.1111/j.1365-2923.2009.03416.x>

<http://pmid.us/19659489>

Context: Colleague surveys are important sources of information on a doctor's professional performance in UK revalidation plans. Colleague surveys are analysed by deriving quantitative measures from rating scales. As free-text comments are also recorded, we explored the utility of a mixed-methods approach to their analysis. Methods: A volunteer sample of practising UK doctors (from acute, primary and other care settings) undertook a General Medical Council (GMC) colleague survey. Up to 20 colleagues per doctor completed an online Colleague Questionnaire (CQ), which included 18 performance evaluation items and an optional comment box. The polarity of each comment was noted and a qualitative content analysis undertaken. Emerging themes were mapped onto existing items to identify areas not previously captured. We then quantitatively analysed the associations between the polarity of comments (positive/adverse) and their related item scale scores. Results: A total of 1636 of 4269 (38.3%) colleagues recorded free-text comments (median = 14 per doctor) and most were unequivocally positive; only 127 of 1636 (7.8%) recorded negative statements and these

were clustered on a subset comprising 80 of 302 (26.5%) doctors. Doctors' overall mean CQ performance scores were significantly correlated with the numbers of colleagues recording positive ($r = 0.35$; $P < 0.0001$) and adverse ($r = - 0.40$; $P = 0.0003$) comments. In total, 1224 of 1636 (74.8%) comments included statements that mapped on CQ items, and statistically significant associations ($P < 0.05$) were observed for 14 of 15 items. Five global themes (innovativeness, interpersonal skills, popularity, professionalism, respect) were identified in 904 of 1636 (73.9%) comments. Conclusions: There is an inevitable trade-off between the capturing of indicators of problematic performance (i.e. adverse statements which contradict a positive scale rating) and the ease with which such statements can be identified. Our data suggest there is little benefit in routinely analysing narrative comments for the purposes of revalidation

Smith,E., et al (2009). Getting ready for user involvement in a systematic review. *Health Expectations.*, 12(2), 197-208.

<http://dx.doi.org/10.1111/j.1369-7625.2009.00535.x>

<http://pmid.us/19236632>

Objective: This paper aims to support the critical development of user involvement in systematic reviews by explaining some of the theoretical, ethical and practical issues entailed in 'getting ready' for user involvement. Background: Relatively few health or social care systematic reviews have actively involved service users. Evidence from other research contexts shows that user involvement can have benefits in terms of improved quality and outcomes, hence there is a need to test out different approaches in order to realize the benefits of user involvement and gain a greater understanding of any negative outcomes. Design: Setting up a service-user reference group for a review of user involvement in nursing, midwifery and health visiting research involved conceptualizing user involvement, developing a representation framework, identifying and targeting service users and creating a sense of mutuality and reciprocity. Setting and participants: Recruitment was undertaken across England by two researchers. Members from 24 national consumer organizations were selected to participate in the review. Main variables studied: Learning was gained about finding ways of navigating consumer networks and organizations, how best to communicate our goals and intentions and how to manage selection and 'rejection' in circumstances where we had stimulated enthusiasm. Results and conclusions: Involving service users helped us to access information, locate the findings in issues that are important to service users and to disseminate findings. User involvement is about relationships in social contexts: decisions made at the early conceptual level of research design affect service users and researchers in complex and personal ways

Ward,E., Miller,J., Graffy,J., & Bower,P. (2006). Contrasting approaches to recruitment in primary care research. *Primary Health Care Research & Development, Forthcoming(-1)*, 1-6.

<http://dx.doi.org/10.1017/S1463423609990223>

<http://pmid.us/19549623>

Aim To describe approaches to recruitment, key challenges and strategies to improve recruitment among research organizations in the UK .**Background** Recruiting research participants is challenging. Less than one-third of studies recruit to target on time. **Methods** Descriptive survey with 31 participants from 22 public and private sector organizations. **Findings** We identified a range of recruitment pathways, highlighting the extensive range of activities required throughout the process. **Methods** reported to improve recruitment were related to project management, context and resources. There were differences in emphasis between sectors concerning prioritization of staff roles, feasibility work and marketing. **Conclusions** Organizations involved in primary care research adopt diverse approaches, yet cross-fertilization between groups is limited

SELF CARE

Jerant,A., et al (2009). Home-based, peer-led chronic illness self-management training: findings from a 1-year randomized controlled trial. *Annals of Family Medicine* 7(4), 319-327.

<http://dx.doi.org/10.1370/afm.996>

<http://pmid.us/19597169>

Purpose: Studies suggest peer-led self-management training improves chronic illness outcomes by enhancing illness management self-efficacy. Limitations of most studies, however, include use of multiple outcome measures without predesignated primary outcomes and lack of randomized follow-up beyond 6 months. We conducted a 1-year randomized controlled trial of Homing in on Health (HIOH), a Chronic Disease Self-Management Program variant, addressing these limitations. **Methods:** We randomized outpatients (N = 415) aged 40 years and older and who had 1 or more of 6 common chronic illnesses, plus functional impairment, to HIOH delivered in homes or by telephone for 6 weeks or to usual care. Primary outcomes were the Medical Outcomes Study 36-item short-form health survey's physical component (PCS-36) and mental component (MCS-36) summary scores. Secondary outcomes included the EuroQol EQ-5D and visual analog scale (EQ VAS), hospitalizations, and health care expenditures. **Results:** Compared with usual care, HIOH delivered in the home led to significantly higher illness management self-efficacy at 6 weeks (effect size = 0.27; 95% CI, 0.10-0.43) and at 6 months (0.17; 95% CI, 0.01-0.33), but not at 1 year. In-home HIOH had no significant effects on PCS-36 or MCS-36 scores and led to improvement in only 1 secondary outcome, the EQ VAS (1-year effect size = 0.40; CI, 0.14-0.66). HIOH delivered by telephone had no significant effects on any outcomes. **Conclusions:** Despite

leading to improvements in self-efficacy comparable to those in other CDSMP studies, in-home HIOH had a limited sustained effect on only 1 secondary health status measure and no effect on utilization. These findings question the cost-effectiveness of peer-led illness self-management training from the health system perspective

Jylha,M. (2009). What is self-rated health and why does it predict mortality? Towards a unified conceptual model. *Social Science & Medicine*, 69(3), 307-316.

<http://dx.doi.org/10.1016/j.socscimed.2009.05.013>

<http://pmid.us/19520474>

The association of self-rated health with mortality is well established but poorly understood. This paper provides new insights into self-rated health that help integrate information from different disciplines, both social and biological, into one unified conceptual framework. It proposes, first, a model describing the health assessment process to show how self-rated health can reflect the states of the human body and mind. Here, an analytic distinction is made between the different types of information on which people base their health assessments and the contextual frameworks in which this information is evaluated and summarized. The model helps us understand why self-ratings of health may be modified by age or culture, but still be a valid measure of health status. Second, based on the proposed model, the paper examines the association of self-rated health with mortality. The key question is, what do people know and how do they know what they know that makes self-rated health such an inclusive and universal predictor of the most absolute biological event, death. The focus is on the social and biological pathways that mediate information from the human organism to individual consciousness, thus incorporating that information into self-ratings of health. A unique source of information is provided by the bodily sensations that are directly available only to the individual him- or herself. According to recent findings in human biology, these sensations may reflect important physiological dysregulations, such as inflammatory processes. Third, the paper discusses the advantages and limitations of self-rated health as a measure of health in research and clinical practice. Future research should investigate both the logics that govern people's reasoning about their health and the physiological processes that underlie bodily feelings and sensations. Self-rated health lies at the crossroads of culture and biology, therefore a collaborative effort between different disciplines can only improve our understanding of this key measure of health status

Kennedy,A., et al (2009). Creating 'good' self-managers?: facilitating and governing an online self care skills training course. *BMC Health Services Research* 9 :93.

<http://dx.doi.org/10.1186/1472-6963-9-93>

<http://www.biomedcentral.com/1472-6963/9/93>

<http://pmid.us/19505302>

Background: In chronic disease management, patients are increasingly called upon to undertake a new role as lay tutors within self-management training programmes. The internet constitutes an increasingly significant healthcare setting and a key arena for self-management support and communication. This study evaluates how a new quasi-professional health workforce - volunteer tutors - engage, guide and attempt to manage people with long-term conditions in the ways of 'good' self-management within the context of an online self-management course. Methods: A qualitative analysis of postings to the discussion centre of 11 online classes (purposively selected from 27) run as part of the Expert Patients Programme. Facilitators (term for tutors online) and participants posted questions, comments and solutions related to self-management of long-term conditions; these were subjected to a textual and discursive analysis to explore: a) how facilitators, through the internet, engaged participants in issues related to self-management; b) how participants responded to and interacted with facilitators. Results: Emergent themes included: techniques and mechanisms used to engage people with self-management; the process facilitators followed - 'sharing', 'modelling' and 'confirming'; and the emergence of a policing role regarding online disclosure. Whilst exchanging medical advice was discouraged, facilitators often professed to understand and give advice on psychological aspects of behaviour. Conclusion: The study gave an insight into the roles tutors adopt - one being their ability to 'police' subjective management of long-term conditions and another being to attempt to enhance the psychological capabilities of participants

Kennedy AP, & Rogers AE (2009). The needs of others: The norms of self-management skills training and the differing priorities of asylum seekers with HIV. *Health Sociology Review*, 18(2), 145-158.

<http://www.atypon-link.com/EMP/doi/pdf/10.5555/hesr.18.2.145>

This paper challenges the notion of a shared social identity resulting from a self care skills training programme through exploring the engagement, experience and outcomes of participants from different social groups: sub-Saharan asylum seekers and gay men. In the former group norms and values about priorities and management of HIV differed significantly from the programme's underlying philosophy of individualism. Some needs were similar, but learning self-management skills was not the priority it was for gay men as pressing needs arising from their asylum status (to address social problems, access welfare and achieve marginal residential status) overwhelmed self care attempts. A focus on self-efficacy and individual behaviour change is likely to leave unaddressed social and material needs, inadvertently adding insult to injury. However, alternative benefits included sharing 'experience' and the perceived 'problem' that being an asylum seeker posed to other people. The contexts of location, needs, identities and social position are important in understanding self care support innovations.

Leydon, G.M. et al (2009). The journey from self-care to GP care: a qualitative interview study of women presenting with symptoms of urinary tract infection. *British Journal of General Practice* 59(564), e219-e225.

<http://dx.doi.org/10.3399/bjgp09X453459>

<http://pmid.us/19566988>

Background: Urinary tract infection (UTI) is one of the commonest acute infections presenting to primary care. Little is known of women's experiences of UTI; self-care strategies and key triggers for their consulting behaviour are also little known. Aim: To explore women's experiences of self-care and their journey to GP care, when faced with symptoms of a UTI. Design of study: Qualitative semi-structured interview study with women recruited to a larger UK trial of different management strategies for UTI. Setting: General practices across four counties in southern England. Method: Twenty-one women were interviewed about the experiences they had prior to their GP visit, self-care strategies, and triggers for help seeking. Interviews were analysed thematically, using principles of analytic induction. Results: Women reported a process of evaluation, monitoring, re-evaluation, and, finally, consulting in order to meet their needs. Four key triggers for consulting were identified: failure to alleviate symptoms through self-care; symptom duration and escalation; impeding normal functioning and the fulfilment of social roles; and concern that it may be or become a serious illness. Conclusion: Although UTI is often self-limiting, when taking patient histories and formulating their management strategies clinicians need to take into account women's often painful experience, their efforts to resolve symptoms prior to consulting, and their fears that the symptoms may indicate something more serious than a UTI

Rose, V., et al (2009). A better model of diabetes self-management? Interactions between GP communication and patient self-efficacy in self-monitoring of blood glucose. *Patient Education and Counseling* Epub ahead of print 29/08/2009

<http://dx.doi.org/10.1016/j.pec.2009.03.026>

<http://pmid.us/19720493>

Objective: The aim of this exploratory study was to investigate the interaction between patient self-efficacy and GP communication in explaining diabetes self-management in a disadvantaged region of Sydney, Australia. Methods: This study was undertaken in South West Sydney with the Fairfield Division of General Practice. We used a cross-sectional survey design to assess patients' self-reported beliefs and behaviours about diabetes self-management. We used hierarchical multiple linear regression to test for interaction effects in diabetes self-management, following tests for clustering using multilevel modeling. Results: Of those eligible for survey, 105 patients completed the telephone survey (72%). There was a significant interaction between diabetes self-efficacy and GP communication in blood glucose testing; high-ratings of GP communication enhanced self-monitoring of blood glucose when patient self-efficacy was high but impeded self-monitoring of blood glucose when self-efficacy was low. There were no significant

interaction effects for the general diet or exercise scales. Conclusion: This exploratory study suggests a complex relationship between patient self-efficacy and GP communication in self-monitoring of blood glucose. It is likely optimal diabetes self-management behaviours are produced by a fit between high patient self-efficacy and high quality GP communication. Practice implications: There is a risk that GPs who are sensitive to their patients' low self-efficacy in self-monitoring of blood glucose may step in and take over the monitoring role and inadvertently reduce self-management

SERVICE ORGANIZATION AND DELIVERY

Mazzaglia,G., et al (2009). Association between satisfaction and stress with aspects of job and practice management among primary care physicians. *Quality in Primary Care* 17(3), 215-223.

<http://pmid.us/19622272>

Background: Reforms introduced in the last decade in Italian general practice, have contributed to the changing role of primary care physicians (PCPs) within the Italian National Health Service, with potential difficulties adapting that may lead to job stress and dissatisfaction. The present study aims to compare job satisfaction and stress levels of PCPs working in primary healthcare teams (PHCTs) with those for practitioners operating in single ambulatory offices, and to assess potential associations with aspects of job and practice management. Method: A postal survey was conducted between January and March 2005 among PCPs working in Tuscany. Data were collected by using a structured questionnaire containing questions concerning personal, professional, job and practice characteristics. The Warr-Cook-Wall scale and the Cooper test were used to assess job satisfaction and stress, respectively. RESULTS: From 3043 PCPs, a response rate of 45.2% was achieved. Significant differences were found between PHCT physicians and solo practitioners in several aspects of their job. Physicians working in PHCTs appeared more satisfied in some aspects of their practice such as organisation, whereas they were less satisfied about workload and interaction with other healthcare providers. Multivariate modelling showed relevant aspects of dissatisfaction and stress, particularly the difficulties of collaboration with other healthcare providers, and access to specialised services. Conclusion: Reform strategies aimed at improving the quality of care among PCPs needs to take into account the contextual determinants of physician satisfaction and stress, and should highlight programmes that might be pursued to improve the integration of PCPs within the Italian National Health System

Meads,G. (2009). The organisation of primary care in Europe: Part 2 Agenda-- position paper of the European Forum for Primary Care. *Quality in Primary Care*, 17(3), 225-234.

<http://pmid.us/19622273>

The contemporary models and trends of European organisational developments in primary care, identified in part 1 of this article, are the subject of analysis and discussion. Four main issues are identified in relation to the future protection and progress of primary care, and a series of policy interventions specified. These are directed at international agencies and action. Two new case study summaries are supplied as illustrations of the dilemmas now being encountered by primary care organisations across the extended Europe. With some supplementary material, the article is an edited version of the 2008 European Forum for Primary Care (EFPC) position paper on the organisation of primary care in Europe

SOCIAL CAPITAL

Oksanen,T., et al (2009) Prospective study of workplace social capital and depression: Are vertical and horizontal components equally important? *Journal of Epidemiology and Community Health* Epub ahead of print 19/08/2009

<http://dx.doi.org/10.1136/jech.2008.086074>

<http://pmid.us/19692720>

Background: Recent studies have emphasised the multidimensional nature of the social capital concept, but it is not known whether the health effects of social capital vary by dimension. The objective of this study was to examine the vertical component (i.e., respectful and trusting relationships across power differentials at work) and the horizontal component of workplace social capital (trust and reciprocity between employees at the same hierarchical level) as risk factors for subsequent depression. Methods: A cohort of 25 763 Finnish public sector employees who were initially free from depression was followed up on average 3.5 years for new self-reported physician-diagnosed depression and recorded antidepressant prescriptions derived from national registers. Results: Factor analysis confirmed the existence of vertical and horizontal components of workplace social capital. The odds for new physician-diagnosed depression and antidepressant treatment were 30-50% higher for employees with low vertical or horizontal workplace social capital than for their counterparts with high social capital at work. In mutually adjusted models, vertical and horizontal social capital remained independent predictors of physician-diagnosed depression and antidepressant treatment. Conclusion: These results highlight the importance of both vertical and horizontal components of workplace social capital as predictors of employee mental health

WORKFORCE

Currie,G., Finn,R., & Martin,G. (2009). Professional competition and modernizing the clinical workforce in the NHS. *Work Employment and Society*, 23(2), 267-284.

<http://dx.doi.org/10.1177/0950017009102858>

Located within a debate about changing organizational forms and new workforce roles this article provides an analysis of policy attempts to modernize the healthcare workforce. Theoretically, the article draws upon sociology of professions literature to focus upon competition within and between professions that impacts upon new roles in the NHS for doctors, designed to combine specialist and generalist knowledge and cross organizational and professional boundaries. The article highlights that attempts by policy-makers to reconfigure the clinical workforce may be constrained due to attempts at occupational closure by more powerful professional groups and by associated concerns about professional identities

Leonard,C., Stordeur,S., & Roberfroid,D. (2009). Association between physician density and health care consumption: a systematic review of the evidence. *Health Policy*, 91(2), 121-134.

<http://dx.doi.org/10.1016/j.healthpol.2008.11.013>

<http://pmid.us/19150579>

Background: Supplier-induced demand (SID) for health care could be a crucial factor of rising health expenditures. However, there is thus far no consensus on the topic. Objective: To assess how physician density (physician-to-population ratio) and health care consumption correlate. Methods: A systematic review of studies retrieved through electronic databases: Medline, Econlit, PsychINFO and Embase. Search, inclusion and quality appraisal were based on standard procedures and applied independently by two researchers. Results: Twenty-five studies, generally of moderate quality, were included. Despite a substantial heterogeneity in study design and data modelling, a significant association between physician density and health care consumption was consistently observed. However, estimates varied according to a number of method parameters such as the definition of the dependent variable (physician volume or care intensity), the geographical entity or the medical specialty under consideration, and the adjustment for confounding factors. Conclusions: The exact importance of SID and the underlying motivations remain poorly understood. We discuss technical issues for better SID assessment. In the absence of more accurate information, limiting physician supply as a measure of cost containment should also be considered cautiously

Phillips, C.B., et al (2009). Enhancing care, improving quality: the six roles of the general practice nurse. *Medical Journal of Australia* 191(2), 92-97.

<http://pmid.us/19619094>

Objective: To describe the evolving roles of practice nurses in Australia and the impact of nurses on general practice function. Design, setting and participants: Multimethod research in two substudies: (a) a rapid appraisal based on observation, photographs of workspaces, and interviews with nurses, doctors and managers in 25 practices in Victoria and New South Wales, conducted between September 2005 and March 2006; and (b) naturalistic longitudinal case studies of introduced change in seven practices in Victoria, NSW, South Australia, Queensland and Western Australia, conducted between January 2007 and March 2008. Results: We identified six roles of nurses in general practice: patient carer, organiser, quality controller, problem solver, educator and agent of connectivity. Although the first three roles are appreciated as nursing strengths by both nurses and doctors, doctors tended not to recognise nurses' educator and problem solver roles within the practice. Only 21% of the clinical activities undertaken by nurses were directly funded through Medicare. The role of the nurse as an agent of connectivity, uniting the different workers within the practice organisation, is particularly notable in small and medium-sized practices, and may be a key determinant of organisational resilience. Conclusion: Nurseing roles may be enhanced through progressive broadening of the scope of the patient care role, fostering the nurse educator role, and addressing barriers to role enhancement, such as organisational inexperience with interprofessional work and lack of a career structure. In adjusting the funding structure for nurses, care should be taken not to create perverse incentives to limit nurses' clinical capacity or undermine the flexibility that gives practice nursing much of its value for nurses and practices

Segal,L., & Bolton,T. (2009). Issues facing the future health care workforce: the importance of demand modelling. *Australia and New Zealand Health Policy*, 6 12. Epub ahead of print 7th May 2009

<http://dx.doi.org/10.1186/1743-8462-6-12>

<http://www.anzhealthpolicy.com/content/6/1/12>

<http://pmid.us/19422686>

This article examines issues facing the future health care workforce in Australia in light of factors such as population ageing. It has been argued that population ageing in Australia is affecting the supply of health care professionals as the health workforce ages and at the same time increasing the demand for health care services and the health care workforce. However, the picture is not that simple. The health workforce market in Australia is influenced by a wide range of factors; on the demand side by increasing levels of income and wealth, emergence of new technologies, changing disease profiles, changing public health priorities and a focus on the prevention of chronic disease. While a strong correlation is observed between age and use of health care services (and thus health care workforce), this is mediated through illness, as typified by the consistent

finding of higher health care costs in the months preceding death. On the supply side, the health workforce is highly influenced by policy drivers; both national policies (eg funded education and training places) and local policies (eg work place-based retention policies). Population ageing and ageing of the health workforce is not a dominant influence. In recent years, the Australian health care workforce has grown in excess of overall workforce growth, despite an ageing health workforce. We also note that current levels of workforce supply compare favourably with many OECD countries. The future of the health workforce will be shaped by a number of complex interacting factors. Market failure, a key feature of the market for health care services which is also observed in the health care labour market - means that imbalances between demand and supply can develop and persist, and suggests a role for health workforce planning to improve efficiency in the health services sector. Current approaches to health workforce planning, especially on the demand side, tend to be highly simplistic. These include historical allocation methods, such as the personnel-to-population ratios which are essentially circular in their rationale rather than evidence-based. This article highlights the importance of evidence-based demand modelling for those seeking to plan for the future Australian health care workforce. A model based on population health status and best practice protocols for health care is briefly outlined

Storey, C., et al (2009) Retention of nurses in the primary and community care workforce after the age of 50 years: database analysis and literature review. *Journal of Advanced Nursing*, 65(8), 1596-1605.

<http://dx.doi.org/10.1111/j.1365-2648.2009.05036.x>

<http://pmid.us/19493133>

Aim: This paper is a report of a study conducted to explore strategies for retaining nurses and their implications for the primary and community care nursing workforce. **Background:** An ageing nursing workforce has forced the need for recruitment and retention of nurses to be an important feature of workforce planning in many countries. However, whilst there is a growing awareness of the factors that influence the retention of nurses within secondary care services, little is known about those that influence retention of nurses in primary and community care. Little is known about the age profile of such nurses or the impact of the ageing nursing workforce on individual nursing specialities in the England. **Methods:** Nursing databases were analysed to explore the impact of age on nursing specialities in primary and community care. The nurse retention literature was reviewed from 1995 to 2006. **FINDINGS:** Workforce statistics reveal that primary and community care nurses have a higher age profile than the National Health Service nursing workforce as a whole. However, there are important gaps in the literature in relation to the factors influencing retention of older primary and community care nurses. Specific factors exist for older nurses within primary care that are unique. Implications for their retention are suggested. **Conclusion:** Particular attention needs to be paid to factors influencing retention of older nurses in primary and community care. These factors need to be incorporated into local and national policy planning and development

Storey,C., et al (2009). Retaining older nurses in primary care and the community. *Journal of Advanced Nursing* 65(7), 1400-1411.

<http://dx.doi.org/10.1111/j.1365-2648.2009.05009.x>

<http://pmid.us/19457002>

Aim: This paper is a report of a study conducted to examine issues associated with the impact of age on the retention of female primary and community care nurses in the National Health Service in England. **Background:** Little is known about why older nurses in the primary and community care workforce leave and what might encourage them to stay. **Methods:** A cross-sectional survey using a semi-structured postal questionnaire was carried out during 2005. Responses were received from 485 (61%) district nurses, health visitors, school nurses and practice nurses in five primary care trusts in England. Data were analysed to test for associations. **Results:** Older nurses were more likely than younger ones to report that their role had lived up to expectations ($P = 0.001$). Issues important for older nurses were feeling valued and being consulted when change was implemented. Important factors encouraging nurses to stay were pension considerations, reduced working hours near retirement, and reduced workload. For those with degree-level qualifications, enhanced pay was a factor encouraging retention ($P = 0.044$). Nurses might leave in response to high administrative workloads, problems in combining work and family commitments ($P < \text{or} = 0.001$), and lack of workplace support ($P = 0.029$). Retirement and pensions advice was not widely available. **Conclusion:** Since two-thirds of nurses were generally happy in their role, it is important that the conditions necessary to maintain this level of satisfaction are continued throughout a nurse's working life. Nurses may all too easily consider leaving prematurely unless policy makers and managers ensure that their working environment reflects the issues nurses consider to be conducive to retention

Taylor,K.S., Lambert,T.W., & Goldacre,M.J. (2009). Career progression and destinations, comparing men and women in the NHS: postal questionnaire surveys. *British Medical Journal* 338 b1735.

<http://dx.doi.org/10.1136/bmj.b1735>

<http://pmid.us/19493938>

Objective: To study the career progression of NHS doctors, comparing men and women. **Design:** Postal questionnaire surveys. Participants and setting Graduates of 1977, 1988, and 1993 from all UK medical schools. **Results:** The response rate was 68% (7012/10 344). Within general practice, 97% (1208/1243) of men, 99% (264/267) of women who had always worked full time throughout their career, and 87% (1083/1248) of all women were principals. Median times from qualification to principal status were 5.8 (95% confidence interval 5.6 to 6.0) years for men, 5.6 (5.4 to 5.8) years for women who had worked full time during training, and 6.8 (6.5 to 7.0) years for all women. Of the 1977

and 1988 graduates in hospital practice, 96% (1293/1347) of men were consultants, compared with 92% (276/299) of women who had always worked full time throughout their career and 67% (277/416) of women who had not. Median time to first consultant post was 11.7 (11.5 to 11.9) years for men, 11.3 (11.0 to 11.6) years for women who worked full time during training, and 12.3 (12.0 to 12.6) years for all women. Women who had not always worked full time throughout their career were over-represented in general practice and under-represented in most hospital specialties, substantially so in the surgical specialties and anaesthetics. Women who had always worked full time were under-represented not only in the surgical specialties but also in general practice. Conclusions: Women not progressing as far and as fast as men was, generally, a reflection of not having always worked full time rather than their sex. The findings suggest that women do not generally encounter direct discrimination; however, the possibility that indirect discrimination, such as lack of opportunities for part time work, has influenced choice of specialty cannot be ruled out