

Does waiting list active management in ambulatory care work? The results of a before-and-after study

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Issue/problem

Waiting list management—in ambulatory as well in hospital care—is one of the most important issues in health care. Waiting list active management practices have been successfully applied in Denmark, Spain, and Sweden. The aim of our study is to evaluate the application of such a programme in cardiology outpatients.

Methods

A controlled before-and-after study was performed in 2008–2009 on four ambulatory centres in Veneto Region. Our sample was: 746 outpatients (367 in the intervention—cardiology—and 379 in the control group—physiatry, respectively). Perceived quality of health care services was measured by administering an anonymous self-reported questionnaire.

Results

We found that before the active waiting list management programme implementation, 52% and 41% in the intervention and control group, respectively, rated health care quality as “fair-good”. After the application of the active management programme, we found an increase up to 53.5% of self-reported quality in the intervention group versus a decrease to 34% in the control group, respectively. The application of the Chi-square test showed a statistically significance between the two groups as for the primary outcome (Chi-2: 5.74; df: 1; *P*-value < 0.05).

Lessons

In many countries, waiting lists are associated with a low perceived quality and trust in health systems and patients in waiting list may result in poorer health status and reduced ability to benefit of care. As appropriateness in waiting list needs more comprehensive strategies, our experience—one of the first in Southern European countries—significantly outlines the importance that “do not leave the patient alone” is a determinant in improving patients’ experience of quality of care.

Higher drop-out rate in non-native patients than in native patients in rehabilitation in The Netherlands

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Background

Drop-out of a rehabilitation programme often occurs in patients with chronic non-specific low back pain of non-native origin. The exact drop-out rate is not known, however. Drop-out patients might have a health disparity compared with programme completers.

Objectives

The first aim of this study was to determine the difference in drop-out rate between native and non-native patients with chronic non-specific low back pain participating in a rehabilitation programme in The Netherlands. The second aim of this study was to determine differences in reasons for drop-out between native patients and non-native patients.

Methods

A retrospective study (*n* = 529) in patient files was performed in two rehabilitation centres and two rehabilitation departments of general hospitals. Patient files were checked for diagnosis, status of origin, sex, age and outcome, i.e. reason for finishing treatment. The difference in drop-out rate between patients of Dutch and non-Dutch origin was tested by Chi-square tests and logistic regression analysis, controlling for age, gender, type of rehabilitation institute and phase of the rehabilitation programme. The differences in frequency in reasons for drop-out between native and non-native patients (*n* = 99) were tested by Chi-square tests.

Results

Drop-out among patients of non-Dutch origin (28.1%) was twice as high as among native Dutch patients (13.7%) (*P* ≤ 0.001). Drop-out occurred among one-fifth (18.7%) of the total patient population. In regression analyses drop-out was related to status of non-Dutch origin, treatment in a rehabilitation centre and the diagnostic phase of a rehabilitation programme. Withdrawal due to different expectations on the content of rehabilitation treatment occurred significantly more frequently in non-native patients (*P* = 0.035).

Conclusion

Patients of non-Dutch origin drop out considerably more frequently than native Dutch patients. Furthermore, this study provided evidence that drop-out in non-native patients is related to different expectations regarding the content of rehabilitation treatment.

Keywords: Rehabilitation, Patient Dropouts, Low Back Pain, Minority Health.

6.4. Workshop: Injury epidemiology

EUPHA section on Injury Prevention and Safety Promotion and EUPHA Section on Organizer: Public Health Epidemiology

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Epidemiology is the backbone of injury prevention. It is “the study of the distribution and determinants of health-related states or events in specified populations” (Last 2001). Such studies are necessary for documenting the amount and distribution of injuries in the population for strengthening the priority setting in prevention activities. They also show the dose–response relationship, do our chosen preventive measures have effect, and to which extent? With limited economical and personnel resources, it is a need to give the policy and decision makers evidence based advices on where

to invest in prevention activities, and inform about which measures have effect.

During the last years the international literature has been growing with regards to evidence based efficient preventive measures. There is however, still a need to increase the number of epidemiological studies in Europe, especial from the Eastern European countries, where up to now quite few such studies have been carried out. One of the aims with this workshop is to inspire such studies to be done.

The first study in this workshop is an analysing of injury mortality in the countries in the European Union (1985–2002), showing great variations between the countries. Especially the Baltic states have high mortality rates. Alcohol is shown

to be a dominant risk factor in all countries, however, increases in importance the further east we are in Europe.

In a study from Italy data from registers on road traffic injuries and safety law violations (2001–2007) are utilized to find any connections between number of fines and number of fatalities and injured on the roads. Weak and non-significant associations were found for most included road behaviours, except for violations of the crash helmet law for motor cycle use.

We know quite much about hospitalized and fatal injuries. But we know very little about injuries giving temporary and permanent impairments and handicaps. All around the globe many projects are now working on finding knowledge to fill this white area of the injury map. Denmark is known for having comprehensive health register of the population with high quality. Such registers have been used to find long-term consequences of injuries. The third study in this workshop shows that injuries have lasting consequences for physical and mental health up to at least 10 years after the injury event, in particular for people sustaining head, neck and back injuries.

Fatal injuries mortality in European Union

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Background

There is a huge premature mortality difference between eastern and western part of the EU (<http://www.hem.waw.pl>). Presented work is based on analysis of differences in access to health among European Union member states. One of the fundamental problems contributing to the gap was fatal injuries mortality, percentage of which was especially high in former SU countries (Estonia, Latvia, Lithuania). The aim of our paper is to discuss and try to explain reasons for such dramatic health gap in Europe.

Methods

Trends in death rates from fatal injuries in European countries in the period 1985–2002 were analysed for 25 EU countries and Russia.

Results

There exists enormous difference mortality from fatal injuries between the EU15 and the EU10. However, also within the EU10 there are as well essential differences in the level of fatal injuries mortality. The Baltic States are an absolute leader in Europe in mortality from injuries. In some of these countries among young and middle-aged men injuries were the main cause of death, before the CVD. The course of fatal injury mortality trends in all considered countries was identical in men and women, although lower in women. In CEE countries alcohol was responsible for 38% of all deaths from injuries in the male population aged 20–64. In the Baltic States this proportion was 48%, and in the EU15 at the level of 29%. In female population this proportion was 29% in CEE countries, 42% in the Baltic States and 19% in EU15.

Conclusions

Observation of the epidemiological situation shows that during the last 15 years there was observed change of trend in fatal injuries mortality and decrease of the injuries risk in the EU. Unfortunately this favorable trend is not present in some Baltic States.

Road traffic injuries and deaths on Italian motorways: are they associated with safety law violations?

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Background

Road traffic injuries are an important problem in Italy. Several measures have been taken to reduce this problem, including law enforcement policies to improve safe road behaviour (e.g. wearing of seat belts and helmets). We analysed recent trends in road traffic injuries and deaths on Italian motorways and their association with safety law violations.

Methods

We used data on both road traffic injuries and safety law violations from Police registries, concerning the period March 2001–August 2007. Using linear regression models, we evaluated two outcomes: (1) the number of fatal injuries and (2) the total number of injuries (fatal and nonfatal combined). Covariates in the analysis were the number of fines: for dangerous speed, for excess of speed, for motor cycle use without a crash helmet, for driving without safety belts, for driving under the influence of alcohol or drugs, and the season of accident occurrence. With the R2 coefficient we evaluated the quality of the model.

Results

During the period considered (2001–2007), a significant decrease of road traffic injury and fatality rates on motorways occurred. Simultaneously, fines for bad road behaviours have increased, except for not using seat belts or motor cycle helmets. We found weak and non-significant associations between fines for most included road behaviours and our outcome variables. The number of fatal injuries, however, is significantly associated with the number of fines for motor cycle use without a crash helmet ($\beta = 0.53$; $P < 0.001$) and the summer ($\beta = 0.20$; $P = 0.03$). Similar associations are shown for injuries with wounded people ($\beta = 0.49$; $P < 0.001$ and $\beta = 0.19$; $P = 0.01$).

Conclusion

Violations of the crash helmet law, as indicated by the number of fines, are associated with nonfatal and fatal injuries on Italian motorways.

Long-term consequence of injury on self-rated health

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Background

Knowledge on long-term consequences of injury on health is vital when injury prevention policies and emergency care are planned. However, few studies have described lasting health consequence associated with injury. This study analyses the relationship between injury and self-assessed health 10 years post-injury.

Methods

The study makes use of public health research databases linking health interview survey information with data from national health registers, in particular hospital data. Using this database the health of a group of Danish injury patients involved in an accident during 1995–2005 was compared to a non-injured group up to 10 years post-injury. The association between self-reported general and mental health and injury-related factors was estimated using logistic regression.

Results

The OR of poor general health and poor mental health were 1.33 (95% CI = 1.22–1.45) and 1.32 (95% CI = 1.18–1.47), respectively, among injury patients compared to non-injured. Though decreasing with time, the effect of injury on general health was significant 10 years post-injury. Injury type was significantly related to health, with neck and back patients reporting poor general health in particular.

Conclusion

Injuries have lasting consequences for physical and mental health up to at least 10 years after injury event, in particular for people sustaining head, neck and back injuries. This emphasizes the need for prevention of these injuries.