CHAPTER V

A Bibliography on:

Strengthening of Public Health Cares Systems

Introduction

This bibliography is based on the literature consulted for this study in relation to the prognosis of epilepsy, the classification of compliance and how to measure it, the purpose, process and advantage of Structural Shared Care, and the domains, and importance of measurement of quality of life.

Besides publications for these issues, several documents are included on Chapter III and Chapter IV.

The list of publications is in alphabetical rank ordered by authors. I limited these bibliographies to these publications, which I found interesting and valuable for preparation of the proposal and doing the study.

1. Cramer JA. (1994). Quaility of Life for People with Epilepsy. Neurologic clinics, 12(1); p. 1-13.

This paper talked about the importance of measurement of quality of life for epileptic patients instead of measuring only physical aspects, particularly seizure frequency and seizure severity or effects of medication. It also talked about the definition and domain measuring of health related quality of life and how to construct an instrument to assess it. It mentioned examples of general and disease-specific measurement of quality of life.

2. Hickman M, Drummond N and Grimshaw J. (1994). The Operation of Shared Care for Chronic Disease. Health Bulletin, 52(2);p. 118-126.

The authors talked about the number and type of shared care for chronic disease in Scotland and England. The detail of shared care is the starting year, the number of patients enrolled and GPs participating, the processes of this scheme particularly GPs role and responsibilities, clinical guidelines for GPs, method of recall system, method of information exchange and storage, and the frequency of clinical review.

3. Lambie DG, Stanaway L and Johnson RH. (1986). Factors which Influence the Effectiveness of Treatment of Epilepsy. Aust NZ J Med 16;p. 779-784.

Despite recent advances in the management of epilepsy, some patients continue to have seizures, which defy therapeutic intervention. This paper wants to examine factors which may influence the successful application of therapy. A survey was carried out of 103 patients, with a previous diagnosis of epilepsy, who had a seizure for which an ambulance was called. It was evident that anticonvulsants are not always used to their maximum potential or under optimal conditions. Problems, which were identified in treatment, included the widespread use of polypharmacy. Patients contributed to failure of seizure control by lack of compliance with therapy (29 patients) and by excessive alcohol consumption (19 patients).

4. Leppik IE. (1988). Compliance during Treatment of Epilepsy. Epilepsia, 29 (suppl. 2);p. S79-S84.

This paper talked about non-compliance that is a major factor in suboptimal control of epileptic seizures. As many as one-third to one-half of persons with epilepsy may be noncompliant. Non-compliance negates the usefulness of the advances made in the diagnosis and treatment of epilepsy and is perhaps the single most important factor in increasing the costs of care for people with epilepsy. Although the issue of non-compliance is very complex, realization that it is a multidimensional problem and varies from patient to patient should help individualize its evaluation and approach. Non-compliance can be described by three dimensions: behavior, extent, and intentionality. The simplest methods for determining non-compliance are measurements of the antiepileptic drug concentration and patient interview. Calculation of a coefficient of variation for serial anticonvulsant drug levels may be more descriptive, however. Education and devices to simplify dosing are the primary strategies for improving compliance.

5. Reynolds EH. (1987). Early Treatment and Prognosis of Epilepsy. Epilepsia, 28 (2);p. 97-106.

Reynolds' prospective hospital-based studies suggest that the prognosis for control of epilepsy is more favorable than previously reported. Approximately three-quarters of newly diagnosed patients can enter prolonged remission on currently available medication. The first 2 years of treatment are crucial in determining the subsequent course of epilepsy. The longer seizures continue, the less likely they are to be controlled. Factors that contribute to the evolution of chronic epilepsy are the presence of brain lesions, neuropsychiatric handicaps, and poor compliance. Early effective treatment may also be important in preventing the evolution of chronic epilepsy. Recent studies have not revealed any significant differences in efficacy between the major antiepileptic drugs, and the choice of drug will therefore be influenced by costs and side-effects, especially cognitive and behavioral effects. The majority of patients with a single unprovoked tonic-clonic seizure go on to develop epilepsy. Studies are required to evaluate the need for and outcome of therapy in such patients. Information about the natural history of untreated epilepsy, and also the possible influence of drug therapy on the prospects for spontaneous remission is lacking.

6. Sander JWAS. (1993). Some Aspects of Prognosis in the Epilepsies: A Review. Epilepsia, 34(6);p. 1007-1016.

This paper said the traditional view of epilepsy as a chronic condition in which the prognosis is consistently poor has been challenged in the last 2 decades. Evidence from population-based studies and from intervention studies in newly diagnosed patients has produced a wealth of information of a much better prognosis. It is now generally accepted that as many as 70-80% of people developing seizures for the first time will eventually achieve terminal remission, whereas the remaining 20-30% will continue to have recurrent seizures despite all treatment. Despite the high recurrence rate after a first epileptic seizure, remission usually occurs early and for most persons; epilepsy is a short-lived condition. The exact role of antiepileptic drugs in this good outcome, however, remains open to debate, because the natural history of the untreated condition is largely unknown. In this article, factors that may influence the prognosis of the epilepsies, including the problems of diagnosis, are reviewed. Special emphasis is given to the issue of spontaneous remission and the question of prognosis of different epileptic syndromes.

7. Shorvon SD and Farmer PJ. (1988). Epilepsy in Developing Countries: A Review of Epidemiological, Sociocultural, and Treatment Aspects. Epilepsia,29 (suppl 1); p. s36-s54.

This paper talked about the difference between epilepsy aspects in developing countries and developed countries. Because of scarce data in developing countries, it is difficult to generalize meaningfully about the enormous diversity of countries and population. Epidemiological studies of prevalence and incidence were reviewed with an emphasis on the problems inherent in work in this area in developing countries. Data concerning seizure type, etiology, and severity of seizures in the Third World were contrasted with those from developed countries. Sociocultural aspects of epilepsy have been poorly studied, and yet were fundamental to effective medical management. The social effects of epilepsy and local perceptions of cause and of treatment were discussed from work in Africa, Asia, and South America. The principles and success of treatment in the Third World may differ considerably in developing and developed countries. In the Third World, medical manpower was scarce and epilepsy was managed essentially by primary care resources, without specialised investigations or personnel. The principles of drug therapy may not be understood by patients and the supply of drugs is often erratic, and these were major reasons for poor compliance with treatment. The recommendation that phenobarbital be extensively used in the Third World, because of its cheapness and efficacy, is also of doubtful merit, as there were well-known and major drawbacks to the widespread use of this drug. Computations of treatment gap figures in three developing countries suggest that between 80-94% of patients with active epilepsy were not receiving anticonvulsant therapy, and cost is only one of a number of reasons for this. The key to improvements in medical treatment lie with a better understanding of the patients' cultural concepts of epilepsy and its treatment, improved drug supply and availability, and efforts to improve education amongst general practitioners and other primary care medical personnel.