Outcome measurements for child health

The British Paediatric Association (BPA) published last year the report of its Health Services Committee on "Outcome Measurements for Child Health". The aim of the report was to recommend a small set of outcome oriented measurements of child health services which health districts (district health authorities) could use to monitor their own performance and to compare themselves with other district health authorities. The committee have confined themselves to drawing up a limited number of measurements which are both practicable and useful as a core for the development of outcome measures in child health.

Two working definitions were used. (1) A health status measurement is a direct measure of some aspect of health in which an improvement is sought, whether or not its relation to any intervention is known. (2) An outcome measurement is a subtype of health status measurement where changes in the measure are known or believed to be directly attributable to a health service intervention.

The committee recommends the following outcome measurements on children resident in a health district:

- Mortality rates in the newborn at 24 hours and 28 days in four birthweight bands from less than 1000 g to over 2500 g.
- The proportion of children aged between 5 and 6 years with congenital deafness whose first hearing aid was fitted later than the age of 15 months.
- The incidence of congenital dislocation of the hip diagnosed after the age of 6 months.
- The frequency of testing for congenital hypothyroidism before the age of 1 week and the proportion of children treated for congenital hypothyroidism who start treatment over the age of 3 months.
- The proportion of children made the subject of an Educational Statement before the age of 3 years in whom the relevant problem was not recognised by a health professional until after the fourth birthday.
- The notification rates for measles and pertussis.
- The proportion of children aged between 2 and 3 in the previous year who were fully immunised against (a) diphtheria, (b) measles, and (c) pertussis by the age of 2 years.
- The proportion of children admitted to hospital with asthma and (a) remain in hospital longer than 72 hours and (b) require both intravenous bronchodilators and intravenous or oral steroids.
- The proportion of children with diabetes mellitus who have concentrations of glycated haemoglobin 50% above the mean normal concentration.
- The number of children under the age of 13 admitted to adult wards as a proportion of all admissions of children of that age.
- The proportion of children admitted for hernia or squint operations who were admitted as day cases.

The committee further recommends that district health authorities monitor the following health status measurements:

(a) Perinatal and infant mortality rates.
(b) Low birthweight rates.
(c) The number of children below the third centile for height on starting school.
(d) Deaths and hospital admissions of children due to road traffic accidents.
(e) The extent of fluoridation.
(f) Smoking in schoolchildren.

The committee finally recommends the establishment of a national confidential inquiry into certain categories of deaths in the age group 12 months to 14 years and a study of bacterial meningitis in children aged between 6 months and 14 years.

Records in child health surveillance

A joint working party of the Health Visitors Association, the Royal College of General Practitioners, the British Medical Association, and the BPA reported last year on professional and parent held records used in child health surveillance.

The main recommendations of the report were that there should be, as in many other countries, a national Personal Child Health Record showing the child's health and progress in growth and development, which should be held by the parents and made available for professionals to obtain or add information whenever the child is seen. The contents of the record should be in line with the programme recommended by the national Working Party on Child Health Surveillance.

General practitioners and other professionals should hold their own records for their child patients in a similar format and should share the information they hold with the parents. It is essential also for health authorities to keep some key management data on every child to monitor the service and to provide a back up to parent held records.

A D M JACKSON
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A D M Jackson

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