Information and intelligence for healthy populations

Important, but maybe just too ambitious

In his report on the resources required to provide high quality health services in Britain, Sir Derek Wanless concluded that “little comprehensive information is collected on the health status of the population,” making it impossible to track, at local level, trends in major risk factors and in patterns of disease. England’s Department of Health has now decided that something must be done to tackle this problem and is seeking views on a proposed new strategy for providing such information, Informing healthier choices: information and intelligence for healthy populations.¹

The government should be congratulated for developing a vision in which real-time, high quality public health data will be delivered via “public health desktops” to a highly trained and integrated public health and local authority work force. It notes correctly that this will be essential for achieving the fully engaged scenario envisaged in Wanless’s first report (about the long term trends affecting the health service in the UK).²

The consultation document sets out, in broad terms, how such a vision could be realised. It recognises that creating a fully integrated system will take time and that there is a need to engage with stakeholders, highlighting the central role that will be played by the public health observatories. However, representatives from the much larger number of analysts located in primary care trusts and strategic health authorities are not included in the list of steering group members to implement the strategy, and they need to be.

Major obstacles exist to obtaining consistent, reliable, and accurate data on levels, trends, and patterns of health and healthcare use at local level, some of which the report acknowledges. For example, the census provides denominator data, but up to one million people were missed by the 2001 census.¹ Many of them live in inner cities,³ and the undercounting combined with high population mobility means that census results from five years ago may be very misleading when applied to current residents in some primary care trusts.

The main source of information on risk factors is the Health Survey for England,⁴ typically collecting data on 16 000 adults each year. While the survey’s changing annual focus provides useful in-depth snapshots of different demographic groups and diseases, changes in data collection can make it difficult to assess trends over time. Information on the incidence of many common disorders can be obtained from the Compendium of Clinical and Health Indicators produced by National Centre for Health Outcomes Development (NCHOD), but nearly all these indicators are based on mortality.

The General Practice Research Database is another
The palliative role of orthopaedics
Orthopaedic procedures can help terminally ill patients and are underused

Palliative care for patients with cancer is well established and provides important benefits. Orthopaedic interventions in terminal care are, however, underused in the United Kingdom, despite the fact that conditions that are amenable to orthopaedic intervention occur often in the terminal stages of cancer. Though the evidence base for many orthopaedic palliative interventions is not strong, since there are no trials, clinical experience and expert consensus suggest that such interventions can ease the made more difficult by the current instability confronting the NHS. No other country has ever attempted anything similar, arguably for good reason. Nevertheless, many other aspects of the proposed information and intelligence initiative build on established structures, such as the public health observatories, cancer registries, and the National Institute for Health and Clinical Excellence (NICE), and do not seek to create new organisations.

The proposed strategy is ambitious. It encompasses not only the population health information and intelligence functions undertaken by professional analysts, but also aims to meet the information needs of the general public, who are more likely to want answers to questions about their own health rather than that of a population. If this initiative is given time and sufficient resources, and is set goals that are realistic, it may just work. This would, however, involve a new way of working in all the organisations involved, from Whitehall down.

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Competing interests: MM chairs and RR is a member of the London Health Observatory's expert advisory committee. SG is also a public health information specialist at Sutton and Merton Primary Care Trust.