Assessing the health care needs of populations — the general practitioner's contribution

CENTRAL to the recent changes in the National Health Service has been the separation of those responsible for providing health services from those responsible for purchasing services for a population.[1] This distinction was based on the assumption that district health authorities would be able to contract for services on the basis of assessments of health care need. Family health services authorities were charged with a similar task.[2] Doctors spend their professional lives assessing the needs of individuals but how are the needs of populations assessed? With so many other demands upon their time, should needs assessment involve general practitioners?

The need for health underlies but does not wholly determine the need for health care.[3] Health care needs are often measured in terms of demand but demand is to a great extent supply-induced. For example, most of the geographical variation in hospital admission rates is explained by the distribution of hospital beds rather than mortality indices.[4,5] A need for health care can be said to exist when an individual has a condition for which there is an effective and acceptable treatment. Though need has been defined as the ability to benefit from health care,[6] few medical interventions have been fully evaluated.[7] Despite technical[8] and ethical[9] reservations, interest in measures of cost utility such as the quality adjusted life year has therefore intensified.

The health care needs of populations have rarely been assessed in ways that are useful to health service managers and planners. Many different approaches to needs assessment are required to underpin the contracting process and these can be considered as three inter-related groups: epidemiological, comparative and consumer defined approaches.

A population's need represents the aggregate of the needs of many individuals. In theory, local needs can be determined by local surveys. In practice, no district has the resources to undertake the requisite research and many of the scales used to measure need have been inadequately validated.[10] The Department of Health has therefore commissioned a series of epidemiologically based research reviews.[11,12] These subcategorize the disease in question, provide estimates of the incidence and prevalence rates of the subcategories and summarize the services available to tackle these, with particular emphasis on their cost effectiveness. The aim is to derive models of care on which district health authorities can base their own service specifications. Focusing on a limited number of well-researched diseases, this approach has an inherent bias towards secondary care. Few outcome studies relate to primary care where interventions can be difficult to define.[13]

As an example of the comparative approach to needs assessment, measures of deprivation can be applied on a geographical basis to highlight areas of need for primary care.[14,15] These unitary indices correlate highly with one another and with standardized mortality ratios.[16] Jarman's underprivileged area score, designed as a measure of general practitioners' workload,[17] is the most widely used though its validity has been questioned.[18] Various comparative data can assist family health services authorities in the identification of putative practice needs, for example, ancillary staffing levels, but the difficulties of interpreting referral rates or PACT (prescribing analyses and cost) data underline the dangers of using measures of practice activity as indices of need.

The third approach acknowledges the importance of gauging patients' perceptions of their own priorities. Consumer feedback can be obtained from established patient participation groups, public meetings, interviews and questionnaires. Rapid appraisal methods are being developed that involve interviews with key members of the community, for example social workers, health visitors, policemen, shopkeepers and postmen, by teams representing health and local authorities.[19] There is a growing literature that purports to explore systematically society's preferences for the allocation of health resources.[20,21] However, the work of the Oregon Health Services Commission has highlighted the ethical and methodological dilemmas such work raises.[22]

All approaches to the assessment of health care needs suffer methodological shortcomings. Epidemiological assessments cannot be translated into service specifications or strategies without incorporating the perspectives of many interested parties: the purchasing team, local people and providers. General practitioners may be asked to contribute to the assessment process in a number of ways:

- Supplying information. Despite the absence of common disease definitions, common classification systems or compatible software[23] and the acknowledged incompleteness of disease registers,[24,25] planners are increasingly interested in the computer databases held by local general practices. Of particular interest is information on those diseases such as asthma treated largely in the community and those groups, such as elderly people, from whom information is routinely collected in general practice.
- The expert opinion. The intimate, detailed knowledge of health professionals, amassed over years, is regularly overlooked. The general practitioner is among those best placed to judge the quality of health services provided locally, and the needs of the practice population or a neighbourhood.
- Special interest groups. General practitioners often have specialist interests in particular priority care groups, for example, children or elderly people. The providers of primary care are seldom represented in discussions of the needs of these groups.
- The consumers' advocate. The views of general practitioners on the district health authority's purchasing strategy are sought increasingly.[26] Districts are seeking endorsement by general practitioners on behalf of their patients of the range of services being procured.
- Audit. The assessment of health care needs is closely related to service evaluation. Many of the activities described — practice activity analysis, the use of health service indicators, patient surveys — fall within a broad definition of audit.[27]

Three main arguments can be advanced against the closer involvement of general practitioners in the assessment of needs and allocation of resources. Health professionals see the concerns of planners as conflicting with their own patient-oriented perspective.[28] However, health professionals have to be involved in the rationing of resources;[29] decisions over whether or not to refer, investigate or prescribe frequently reflect implicit prioritization. Patients expect their doctors to defend their interests, and there is no evidence that patients would prefer health care professionals to delegate the responsibility for resource allocation to managers.

It is often argued that the assessment of needs requires particular epidemiological, economic or statistical expertise. The

white paper, *Working for patients,*[1] has helped to create the impression that needs assessment is an arcane activity undertaken by expert teams headed by a director of public health on behalf of purchasing authorities. In practice, numeracy, an awareness of the configuration of local services, negotiating skills and common sense are much more important.

The third and perhaps most powerful disincentive is the time that might be involved in the assessment of needs. However, pleas for extra resources will increasingly have to be argued with more sophistication. A request for extra staff is more likely to be successful if argued in terms of particular practice needs. Growing numbers of general practitioners are already assessing their practice population's needs and not all of them are fund holders.[30]

Meaningful assessment of needs is the key to successful purchasing and, by extension, to the resolution of contraindications inherent in the concept of an internal market.[31] Assessment of needs and the use of epidemiological skills for community oriented primary care are not new.[32-35] What is new is the requirement for a coherent and more explicit approach to the task at district health authority, family health services authority and practice level. The formalization of needs assessment may not result in more than marginal change to the way services are provided in the short term,[36] but general practitioners are unlikely to escape involvement in the process.

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