

Needs assessment in primary care: general practitioners' perceptions and implications for the future

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SUMMARY

Background. Health needs assessment can guide the appropriate shift to primary care by identifying the most effective and efficient resource allocation to meet the needs of populations. Assessing health care needs will be a continuing challenge for primary care trusts in Scotland (or equivalent groups in other parts of the United Kingdom); however, lessons must be learned from the experience of needs assessment that followed the 'internal market' reforms of the 1990s.

Aim. To examine general practitioners' (GPs') awareness and experience of needs assessment, to identify barriers to needs assessment in primary care, and to ascertain how better progress might be made in the future.

Method. A postal questionnaire survey of 1777 Scottish GPs (a one-in-two sample) was combined with a semi-structured interview survey of 'lead' GPs from a random sample of 64 mainland Scottish practices between May and August 1996.

Results. Sixty-five per cent (1154) of GPs responded to the questionnaire, of which 54% (965) were completed. Over 73% (47) of interviews were completed. Most GPs were unfamiliar with the concept of needs assessment and there was no evidence that needs assessment had influenced commissioning decisions. Most GPs argued that it was not a 'core' activity and that they lacked training in the relevant skills. While the attitude of the majority was indifferent, cynical, and sometimes hostile, a minority, comprising mostly younger fundholders, was more enthusiastic about needs assessment.

Conclusion. The motivation and attitude of the majority of GPs present a barrier to needs assessment in primary care. GPs will require more resources and training if they are to undertake this responsibility. Most GPs believe that incentives (financial or organisational) will be necessary. Primary care trusts and equivalent structures should be aware of

these attitudes as they seek to establish plans based on estimates of population needs in defined locations.

Keywords: needs assessment; primary care; doctors' attitude.

Introduction

THE involvement of general practitioners (GPs) in health needs assessment was intended, as part of the National Health Service (NHS) reforms of the early 1990s,¹ to enable fundholding GPs to shape local services by allocating resources according to the needs of practice populations. This was to be achieved by developing conducive working relationships among local health, social, and voluntary agencies. Building on the community-oriented primary care model,² health professionals were expected to assume new roles and responsibilities,³ including 'partnerships' with patients.⁴

These fine aspirations were not matched by the experiences of many GPs. The NHS reforms of 1990 brought division⁵ and despondency⁶ within general practice. Growing opposition to the proposed expansion of practice-based fundholding schemes led to the emergence of alternative commissioning structures and a trend towards flexible, locality-based models considered more acceptable to local stakeholders.⁷ Nonetheless, needs assessment was also seen as a fundamental part of these locality-based approaches.⁸

Following the publication of the Scottish⁹ and English¹⁰ White Papers, general practice stands at the threshold of a new NHS with alternative primary care organisations and GP groups. The Scottish White Paper, *Designed to Care*, explicitly refers to the role of primary care trusts and local healthcare cooperatives in assessing need and developing plans that reflect clinical priorities for health improvement of populations within their remits. However, if the mistakes of the 1990 reforms are not to be repeated, it is essential that the attitudes of GPs (that is, all GPs and not just a vocal minority) should be understood.

There are examples of GP involvement in practice-based needs assessment,^{11,12} but the extent is unknown. Others have argued that needs assessment is not, and should not become, the domain of GPs, who lack the time and expertise for this type of activity.¹³ This divergence of views and experience was recognised by the Scottish Needs Assessment Programme (SNAP),¹⁴ which, through its primary care network, aims to develop and advise GPs on effective methods for assessing and meeting need within practices. SNAP therefore set out to ascertain how needs assessment in primary care might improve the health benefits of commissioning in Scotland. This paper describes the GP component of the study; a health board perspective is reported elsewhere.¹⁵ (For the purpose of discussion, the term 'health board' is used synonymously with 'health authority').

Method

The research was conducted by a GP principal studying for a Master of Public Health degree at the University of Glasgow. The study comprised two separate parts: a postal self-completed

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questionnaire survey, primarily to ascertain the extent of needs assessment activity in general practice; and face-to-face semi-structured interviews with GPs to obtain more textured information, including their views on the shift to primary care, GP commissioning, and health needs assessment. Fundholding status, sex, year of graduation, and membership of Royal College of General Practitioners (RCGP) were recorded. Other variables were compiled from key themes identified in an exploratory survey of GPs, developed following a succession of meetings with executive members of SNAP and refined after pilot studies in Lanarkshire.

Half (1777) of Scotland's GP principals in post on 1 April 1996 were sent questionnaires between May and June 1996, while interviews were conducted with a randomly selected sample of 47 GPs. They were the 'lead' GPs in each of a random sample of 64 mainland practices that included all three major categories — fundholding (FH), nonfundholding (NFH), and primary care purchasing initiative (PCPI) — in equal proportions.

Questionnaire data were analysed using the Statistical Package for Social Sciences (SPSS) with chi-squared tests of association. Interviews were taped and analysed by rapid modified transcription, in which key points were clarified, condensed, and linked via categories by the researcher, weighting both intellectual and emotional dimensions. Transcriptions and their interpretations were assessed for validity by two lecturers in public health.

Results

Overall, 1154 (65%) GPs participated in the postal survey. This comprised 965 (54%) who returned completed questionnaires and 179 (11%) who supplied alternative responses, of whom 158 (9%) expressed their reasons for non-completion on reply slips provided. Those who had completed questionnaires were representative of purchasing activity (25% FH, 63% NFH, 12% PCPI) and sex, but had a small excess of younger doctors (year of graduation was used as a proxy for age). There were significant positive associations between fundholding and graduation during the years 1975 to 1979 ($\chi^2 = 17.8$, $df = 2$, $P < 0.001$) and 1980 to 1984 ($\chi^2 = 7.8$, $df = 2$, $P = 0.02$). Response rates varied among health board areas of origin, ranging from 45% (Ayrshire and Arran) to 72% (Highland).

Forty-seven (73%) face-to-face interviews were completed. Those who agreed were more commonly purchasers (16 FH, 13 NFH, 18 PCPI), male, and members of the RCGP.

General tenor of responses

The main reasons identified for non-participation in needs assessment were the same in both surveys: 'no time', 'no reward', and 'no interest'. Replies suggested that morale was low and that some GPs were stressed, with many complaining about an unacceptable workload. GPs admitted feeling disempowered and disillusioned, especially older GPs, several of whom were anticipating retirement. It was clear that, in the minds of GPs, needs assessment was linked to the 1990 reforms and, as such, was not value-free. While most comments regarding the reorientation of the NHS were negative (Box 1), a minority welcomed a transfer of power (5/47) and executive role (4/47) to the GP (Box 2).

Awareness and experience of needs assessment

The postal survey revealed that 423 (44% of responders) GPs claimed that their practices were currently measuring the health care needs of patients, this being strongly associated with purchasing activity (Table 1). However, the face-to-face interviews suggested that a larger majority of GPs was unfamiliar with

- A 'nebulous concept', 'poorly thought out', 'all things to all people', 'implications are not spelt out'
- A political 'banner', a 'sop', 'lulling GPs into believing they had influence'
- The 'dumping' of services
- Antagonism and instability within the NHS, 'getting rid of the sick old woman of the NHS'
- A transfer of purchasing 'power', 'resources', 'teeth', 'we have been led long enough'
- 'New opportunities', a 'new contract'

Box 1. Comments from GPs about the shift in the balance of care (a primary care-led NHS).

- The 'status quo', 'clinical generalist', patients' 'advocate'
- 'Not just a filter to secondary care', a greater 'voice', 'a voice to which people will listen'
- An 'expert', not perceived as 'a lower caste', not 'professionally undervalued by consultants'
- A 'power structure', possessing 'budgetary control'
- 'Executive', 'manager', director', 'negotiator'

Box 2. Comments from GPs about their role within the reoriented NHS (a primary care-led NHS).

Table 1. Reported needs assessment by fundholding status.

Fundholding status	Number (%) of responders (n = 423)
FH (n = 230)	145 (63)
PCPI (n = 115)	57 (50)
NFH (n = 600)	221 (37) ^a

^a $\chi^2 = 56.6$, $df = 4$, $P < 0.001$

needs assessment. The concept provoked antagonism in a proportion of interviewees and apathy in others. Moreover, with the exception of practice annual reports, the focus of health needs was very much on the individual patient and not the intended whole practice population.

Four (three FH, one NFH) out of 47 GPs interviewed had adopted a formal approach to needs assessment. These four practices had used a combination of methods, such as postal surveys, practice profiling using routinely collected data (sources: Community Health Index, Registrar General Office, Census data, and Scottish Morbidity Record), and practice-held data. Other methods employed were a nominal group technique (employed by one NFH) and a health alliance approach, involving social workers, community nurses, and patient representatives. Despite this effort, only two of the four practices (both GP fundholders) had identified priorities following needs assessment, to which neither had yet committed financial resources. The remaining two were sceptical about any perceived benefit resulting from their efforts; the nominal group approach produced an unrealistic 'wish list' and another needs assessment had exposed the need for 'substantial investment' outwith current resources.

General practitioners remained to be convinced of the practical value of needs assessment. While a needs-based approach was considered the 'ideal', most GP fundholders admitted that the purchasing process was being driven by a desire to confront issues of service quality (e.g. waiting times) as a means of improving the process of care.

Who should be responsible for needs assessment?

Table 2 summarises the views of GPs in the postal survey on the organisation of needs assessment. 'Health boards' were selected most frequently (57%) and central government least often (13%). The choice of agency was associated with the age, sex, fundhold-

Table 2. GP selection of agencies that should have responsibility for needs assessment.

Agency	Number (%) of responders (n = 953)
Health boards	541 (57)
Primary care teams	517 (54)
Locality groups	481 (51)
Public health doctors	417 (44)
GPs	371 (39)
Scottish Office	303 (32)
Central government	124 (13)

- The provision of health care on the basis of need underpins the philosophy of the NHS, primary care, and public health policy.
- Most GPs are unsophisticated in their understanding of health needs assessment and very few have experience of assessing population need.
- Barriers to health needs assessment are:
 - GP-based: disinterest, scepticism, resistance, lack of knowledge and skills;
 - practice-based: lack of time, staff, and communication, and inadequate information;
 - locality-based: poor organisation, coordination, and collaboration; and
 - health board-based: professional boundaries, role conflict, 'token' representation.
- Resource implications of health needs assessment include financial, organisational, training, and educational methods appropriate to the needs of GPs.

Box 3. Summary of main findings.

- GP training: supported by protected time, professional advice, and support network
- Incentives: financial rewards and/or organisational enhancements for practices
- Team-building: delegation of tasks, integration of all stakeholders, 'democratisation'
- Research: evidence-based approach to assess health benefits of needs assessment.

Box 4. Key points.

ing status, and health board of the GP. Younger GPs more often selected 'public health doctors' ($\chi^2 = 29$, $df = 8$, $P < 0.001$) and older doctors selected 'Scottish Office' ($\chi^2 = 16$, $df = 8$, $P < 0.043$) as their choice of agency to organise needs assessment; male GPs favoured 'health boards' ($\chi^2 = 6.7$, $df = 1$, $P = 0.009$) and 'Scottish Office' ($\chi^2 = 4.8$, $df = 1$, $P = 0.029$). Female GPs were more likely than their male colleagues to choose the 'primary care team' ($\chi^2 = 8$, $df = 1$, $P = 0.005$). Fundholding was strongly associated with the choice of 'primary care team' ($\chi^2 = 23$, $df = 2$, $P < 0.001$) and 'GPs' ($\chi^2 = 12$, $df = 2$, $P < 0.003$). Geographically, there was a marked difference in preference for 'locality groups', which was highest in Dumfries and Galloway and lowest in Grampian ($\chi^2 = 42$, $df = 15$, $P < 0.001$). GPs who reported having experience in assessing need were more likely to choose primary care structures, such as 'primary care team' ($\chi^2 = 33$, $df = 2$, $P < 0.001$) and 'GPs' ($\chi^2 = 26$, $df = 2$, $P < 0.001$).

Barriers to involvement in needs assessment

In the interviews, perceived barriers to involvement in needs assessment were resistance, disinterest or scepticism, and lack of training, additional resources, and remuneration. GPs resented dictatorial 'top down' approaches, particularly if this required additional administration, the benefits of which were, in their opinion, unproven.

Two-thirds of GPs considered needs assessment a 'non-core' activity and almost all (41/47) GPs wanted additional payments or funds, depending on the time required for the task. There was general support for broad-based 'on-site' training for needs assessment, but advanced skills were considered necessary only for GPs directly involved in commissioning.

Practice-based barriers included inadequate information systems, lack of time and staff, and poor communication. Local problems included poor organisation, lack of coordination, and poor collaboration among GPs and with health boards.

Interviewed GPs demonstrated a divergence of opinion regarding the role and responsibilities of public health doctors in needs assessment. Some saw no role, while the majority felt that, although GPs and public health doctors should share responsibility, most public health doctors were remote from the realities of daily practice. Some GPs were suspicious of public health doctors who, they argued, were required to take corporate responsibility for health board decisions. Instead, some GPs advocated an independent public health body.

The interviewed GPs expressed reservations about engaging their health visitors in tasks such as needs assessment, or for involving patients. Only one-third of GPs among either group had surveyed consumer opinion, the use of which was strongly associated with a later year of graduation ($\chi^2 = 21$, $df = 2$, $P = 0.007$) and fundholding status ($\chi^2 = 21$, $df = 2$, $P < 0.007$).

Discussion

Given the unfavourable climate of 'questionnaire fatigue'¹⁶ and the political turbulence of 1996, the number of completed questionnaires was predictably low. Hostile comments from those who returned the questionnaire uncompleted suggest that the high levels of negativity and hostility from those who did complete it are likely still to be an underestimate of the antagonistic mood.

A likely explanation for the higher response rate to the interview survey is that the researcher made personal contact with practices. The discrepancies in findings between the two parts of the study raise the possibility of flawed questionnaire design in terms of agreed definitions, specifically the term 'needs assessment', which is subject to different interpretations.¹⁷

A picture emerges of disillusioned and disenfranchised GPs, whose opinions are diverse and disparate, as are their practices. Parallels can be drawn between the diversity of opinion described and the pattern of heterogeneity identified by Petchley's study of GPs' orientation to practice.¹⁸ This research demonstrates the difficulty that some GPs experience in reconciling their traditional role as patient's advocate with a wider public health concern. The risk associated with the individual perspective in general practice is that the provision of health care is sometimes inversely related to need.¹⁹ However, given most GPs' unfamiliarity with health needs assessment and their failure to adopt the population approach, their estimation of its potential contribution to health care must be interpreted with caution. Results from the parallel study of health board officials emphasised the perceived importance of GP involvement in needs assessment but recognised that all but a few GPs were committed to the planning process.

The consensus view among GPs was that they lacked the time, skills, and the inclination for health needs assessment. These very real practical barriers, coupled with the perceived futility of identifying unmet need for which resources cannot be found, make GPs understandably hesitant about involvement in needs assessment.

Nonetheless, some GPs, particularly younger fundholders,

were more positively disposed towards assessing patient need at population level. Indeed, there was a clearly identified minority of GPs who saw great opportunities in the reforms and were stimulated personally and professionally. Health needs assessment at locality level was less strongly supported in areas of high levels of fundholding compared with areas with well developed locality structures.

While strengthening of professional relationships was an integral component of the reforms, this research shows that effective collaboration between general practice and public health is still limited and its potential for development compromised by suspicion, poor communication, and conflict.

Conclusion

This paper provides valuable insight into the current debate, as there must be real doubt that the majority of GPs are ready to accept the challenge of needs assessment or take a major role in strategic planning. This finding has important implications for discussions about the contribution of GPs in directing the new primary care trusts (or equivalent structures) and their capacity to deliver this major plank of the Government's White Paper on health.¹⁰ By the same token, the contribution of GPs towards delivering the aims of the English²⁰ and Scottish²¹ Green Papers on public health must also be questioned, since health inequalities — the stated target of both Green Papers — have, by definition, a population rather than an individual perspective.

To reverse the situation, motivation, training, and rewards might ameliorate negative views of needs assessment, but, as past experience of health promotion payments has shown, incentives alone do not change doctors' attitudes. Research directed specifically at identifying the tangible health benefits of needs assessment might counter scepticism and disinterest. Consideration might also be given to the creation of an independent public health agency or commission.

Nor should it be assumed that health needs assessment is the exclusive remit of GPs (or even doctors). Effort should be made to involve all stakeholders in health needs assessment, including patients, without whom 'democratisation' of the NHS cannot be achieved. Finally, a shared vision, common language, understanding of professional roles, and closer working relationships might, in time, substitute partnership for alienation.

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