NEEDS AND OUTCOME ASSESSMENT (NOA) IN PRIMARY HEALTH CARE

Report on a WHO Meeting

Heraklion, Greece
28–30 May 1998
TARGET 28
PRIMARY HEALTH CARE

By the year 2000, primary health care in all Member States should meet the basic health needs of the population by providing a wide range of health-promotive, curative, rehabilitative and supportive services and by actively supporting self-help activities of individuals, families and groups.

ABSTRACT

The Workshop on Needs and Outcomes Assessment (NOA) in Primary Health Care, convened by the WHO Regional Office for Europe, was attended by family physicians and nurses, general physicians, social scientists, public health physicians and other experts in this field. The objectives were to review the methodology that different centres used to assess needs and outcomes, to identify the basic elements of a common approach to this methodology and to identify potential partners for implementing such an approach. The discussions showed that, although the participants' centres differed in circumstances and priorities, they shared several common factors: the identification of specific populations or groups within them, a multidisciplinary approach and involvement of the community. The participants concluded that NOA is highly relevant for the further development of effective primary health care and for the strengthening of the broader concept of primary health care. NOA is necessary at two levels (individual practice and district level) and can use a global or disease-specific approach at each. Cooperation with the community adds to the validity and impact of the process. NOA must involve professional, patient and community perspectives and should utilize a mix of locally appropriate methods, and multiple data sources should be considered. Specific indicators for NOA should be identified and tested. Resources and training would be required. The participants recommended that WHO have a leading role in advocating this approach and developing and disseminating material to help local teams in different countries to carry out NOA. The Workshop should mark the beginning of a process of exchanging experiences and information about developments in other countries.

Keywords

PRIMARY HEALTH CARE – standards
OUTCOME AND PROCESS ASSESSMENT (HEALTH CARE)
HEALTH SERVICES NEEDS AND DEMAND
EUROPE

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<table>
<thead>
<tr>
<th>CONTENTS</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary</td>
<td>1</td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Topics discussed</td>
<td>3</td>
</tr>
<tr>
<td>Community-oriented primary care (COPC)</td>
<td>3</td>
</tr>
<tr>
<td>Community involvement</td>
<td>3</td>
</tr>
<tr>
<td>Intersectoral cooperation</td>
<td>4</td>
</tr>
<tr>
<td>Prerequisites for NOA</td>
<td>4</td>
</tr>
<tr>
<td>Health care information systems</td>
<td>5</td>
</tr>
<tr>
<td>Multiple methods and data sources to define needs and outcomes of care</td>
<td>5</td>
</tr>
<tr>
<td>Strengths and weaknesses of different methods and data sources</td>
<td>5</td>
</tr>
<tr>
<td>Levels at which to conduct NOA</td>
<td>6</td>
</tr>
<tr>
<td>Quality of care development (QCD)</td>
<td>7</td>
</tr>
<tr>
<td>Networks</td>
<td>7</td>
</tr>
<tr>
<td>Conclusions</td>
<td>7</td>
</tr>
<tr>
<td>Current constraints and opportunities for NOA in Europe</td>
<td>7</td>
</tr>
<tr>
<td>Conclusions concerning methodologies</td>
<td>8</td>
</tr>
<tr>
<td>Recommendations</td>
<td>8</td>
</tr>
<tr>
<td>Annex 1 Working papers and background material</td>
<td>11</td>
</tr>
<tr>
<td>Annex 2 Community-oriented planning and evaluation cycle (COPEC)</td>
<td>13</td>
</tr>
<tr>
<td>Annex 3 Possible methods and indicators for assessing needs and outcomes</td>
<td>14</td>
</tr>
<tr>
<td>Annex 4 Participants</td>
<td>17</td>
</tr>
</tbody>
</table>
The Working Group on Needs and Outcomes assessment (NOA) in Primary Health Care was convened by the WHO Regional Office for Europe in cooperation with WHO headquarters and attended by 14 participants from 11 countries, including people nominated by

Addendum. The workshop was informed of the recent demise of Sidney Kark, whose seminal work in the area of community-oriented primary care was the basis for the development of needs assessment in PHC. It was recommended that the meeting should be dedicated to his memory.

**INTRODUCTION**

The Working Group on Needs and Outcomes assessment (NOA) in Primary Health Care met in Heraklion, Crete from 28 to 30 May 1998. The Group was convened by the WHO Regional Office for Europe in collaboration with WHO headquarters, and comprised family physicians and nurses, general physicians, social scientists, public health physicians and other experts in this field. The objectives of the Workshop were to review the methodology used to assess needs and outcomes by the different centres, to identify the basic elements of a common approach to this methodology, and to identify potential partners for implementing a common approach.

During the discussions, it was evident that although the centres from which the participants came were functioning in different circumstances and had different priorities, there were several common principles. These were the identification of specific populations or groups within the population, a multidisciplinary approach and the involvement of the community. Participants considered it important to distinguish between health needs and health service needs as community priorities were diverse, for example, housing, transport and roads. They noted that most of the work was focused on the assessment of needs, while work on the assessment of outcomes was less developed. In this respect, the methodology used in quality development was relevant.

The working group concluded that NOA is highly relevant for the further development of effective primary health care and for strengthening the broader concept of primary health care. NOA is necessary at two levels: individual practice and district level, and can use a global or disease-specific approach at each level. Cooperation with the community adds to the validity and impact of the process.

The meeting also concluded that NOA must involve professional, patient and community perspectives, that a mix of locally appropriate methods should be utilized and that multiple data sources should be considered. Specific indicators for NOA should be identified and tested from databases held at the primary care level, other routine data such as census and hospital utilization data, a patient involvement/community participation initiative, and a specific questionnaire survey of the population. Resources and training will be required.

Recommendations made included that WHO should have a leading role in advocacy for this approach and in the development and wider dissemination of relevant material to help local teams in different countries carry out NOA. The Workshop should mark the beginning of a process of exchange of experience and information about developments in other countries, but it was agreed that the formation of a formal network at this stage would not be necessary.
other units in the WHO Regional Office for Europe (EURO) and two resource people sponsored by WHO headquarters. Participants also came from two WHO collaborating centres for PHC and from a network (Tipping The Balance towards PHC) with which EURO has a Memorandum of Understanding. Two staff members from WHO headquarters also participated in the meeting, from the Division of Analysis, Research and Assessment and from the Division of Human Resources Development and Capacity Building. The list of participants is at Annex 4. Professor P. Kekki was nominated Chairperson and Dr. S. Murray Rapporteur.

Professor N. Tsaparas, Deputy Dean of the Medical Faculty of the University of Crete, welcomed the participants and Mrs. E. Bredaki, representing the Ministry of Health and the Secretary General of the Region of Crete, opened the workshop.

The health care reforms witnessed in Europe in the last decade have added a fresh impetus for the development of effective PHC. In northern and western Europe PHC is seen as a means to reduce costs while maintaining equity, access and effectiveness. In southern Europe the main drive has been to decentralize services and improve access. In eastern Europe the rediscovery of PHC may help re-orientate the present polyclinics, staffed by specialists managing vertically organized programmes for specific conditions to generalist and population-based perspectives with general practitioners serving as gatekeepers to hospital care. In the years ahead increasing cost restraints, demographic changes and a shift of care from hospital to the community will create new kinds of challenges and demands for PHC.

The concept of PHC which WHO has consistently supported is based on four service elements:

• diagnostic and curative services provided to the individual (primary medical care)
• health promotion, disease prevention and rehabilitation aimed at the individual
• care for the individual within the context of the family and work environment
• involvement of PHC in improving the health of the community

and two elements related to the user and the community:

• partnership with the user in decision-making related to his/her health care
• active participation of the community in health promotion and disease prevention.

These two latter concepts have not been widely adopted by Member States. In 1991, a EURO working group considered that needs assessment should be the basis for allocating resources, prioritizing needs, and planning and evaluating programmes (EUR/ICP/PHC 340) More recently, assessing needs and outcomes has been realized to be fundamental to appropriate and quality care. In 1994, a WHO-WONCA conference suggested that tools should be developed and used to define people’s health needs both as individuals and as members of communities, and that national and community data should be balanced by the practice-based analysis of individuals and families. A functional model of NOA must now be developed at local level, incorporating community participation and intersectoral cooperation.

This meeting thus sought to develop a practical framework for health needs and outcomes assessment in primary care relevant to the various current circumstances in European countries. Experts from various backgrounds met in two groups intensively over three days to identify common aspects of methods which have proved to be successful in various countries with a view to developing a practical European-wide framework for assessing needs and outcomes in primary care.
TOPICS DISCUSSED

All 14 participants outlined their experiences in relation to NOA. There were differences in the details but many similar elements and concepts were recognized. These important common themes are now summarized. More details are contained in the working papers which are listed in Annex 1.

Community-oriented primary care (COPC)

Several PHC centres in Europe, notably in Finland, Greece (Crete), Israel (Jerusalem), Sweden (Linkoping) and the United Kingdom, have adopted a population-based approach that combines clinical care with public health to carry out a systematic identification of the major health problems of the population served. This approach is often described as community-oriented primary care (COPC), although many PHC centres do not use this term to identify such work. All participants subscribed to the distinctive features of this concept which are:

- a well defined population or community;
- the use of epidemiology to assess the health needs of the population served;
- collaboration with the community to identify priorities and resources and plan activities;
- health service interventions that integrate curative, rehabilitative, preventive and promotive care;
- multidisciplinary cooperation to plan and carry out the required interventions;
- regular assessment of the outcomes of the programmes.

Participants drew the parallel between individual clinical diagnosis and treatment and community diagnosis and intervention, and affirmed the necessary involvement of the individual patient in the former and the involvement of the community in the latter.

This approach can improve outcomes, and has increased cervical smear screening rates in parts of Crete and the United Kingdom. The centre in Israel had successfully focused on population groups such as the elderly and disease groups such as hypertension.

The paper from Sweden stressed the importance of establishing measurable outcomes and illustrated the use of the community-oriented planning and evaluation cycle (COPEC) to decrease accident rates and to improve the care of the elderly (Annex 2). The meeting considered that although the tools for implementing COPC are straightforward this approach has not been adopted on a widescale because of the lack of a suitable policy environment including the appropriate financial organizational and managerial conditions.

Community involvement

The social scientists present suggested that health needs assessment should begin with individual and community perceptions of need, and not be imposed by professionals acting alone. For example, a community action group in Liverpool, stating that “professionals should be on tap, not on top”, had taken charge of their community health issues. Osler’s words were paraphrased: “listen to the community, it is not only telling you the diagnosis, but many solutions”. The use of a book and a national organization to help communities identify and assemble data on which to act was illustrated from the United States. This Community substance abuse indicators handbook
allowed data from many sources to be set out easily for local action by the community. This could be considered a proxy for any chronic relapsing condition, and the indicators were specific and measurable. Methods for developing and matching community-defined health needs with health care development for a Somali community in Manchester (United Kingdom) included the assembly of data from questionnaires on a post-code-defined basis and interviews with key informants, and the development of an action plan by professional and community leaders.

Questions as to how professionals could share information with communities and vice versa. While professionals should identify needs and resources in the community and what has to be done to maximize community action, the community has a right to its own health care information so it can make fully informed decisions. The suggestion was made that Health for all should be re-ordered to All for health to stress the active participation of the public as well as professionals in seeking health.

Many centres demonstrated that community perceptions of need differ from professional perceptions of need. It was important to distinguish between health needs and health service needs; in several instances the community’s priorities were wider, for example housing, transport and environmental hazards. Community targets must be identified and addressed and progress evaluated using quantitative and (more likely) qualitative methods as well as process evaluation. The community can be considered as part of the health care team, and professionals must recognize that the community is practising prevention through, for example, sports clubs and lunch clubs.

**Intersectoral cooperation**

The importance of intersectoral cooperation to NOA was mentioned not only by the above COPC centres, but especially when the community has been involved in assessing needs. Isolated initiatives in the United Kingdom (England and Scotland) have led to the setting up of interagency partnerships or a health forum to assess needs and monitor objectives and outcomes at local level. In Norway, intersectoral planning with official medical input is well established for populations of around 5000. In Belgium (Flanders) GP prevention coordinators engage in multisectoral planning and local priority setting at the level of 300 000 persons. In Portugal the health care reform process is starting local health systems, combining primary health care centres, hospitals and other health and social partners in geographic/population areas of 100 000 to 500 000, and performance-related renumeration is being introduced.

**Prerequisites for NOA**

Experience from the WHO collaborating centre for PHC in Finland suggested that a functioning team was a prerequisite for NOA, and that much team-building and management support was necessary before NOA could succeed. Concepts such as needs assessment, how to set priorities, and how to measure the achievements would also require training as they are quite alien to many GPs and other PHC team members. However, some community nurses are trained in community profiling. A considerable evolution in thinking would be necessary for GPs to consider population as well as individual patient needs, and to espouse a community development approach. Analytic thinking, new skills in assessment and evaluation methods and learning to work in teams will be important and necessary training areas. Multiprofessional training connected with practical problem situations would be an effective method.
The lack of time and the urgency of the many pressing needs in primary care are universal. An appropriate policy environment and financial incentives are necessary for such changes to happen. An effective information system, adequate time and a well defined population are other prerequisites. The centre in Finland has already started to use advanced information and telecommunication technologies in its regular training activities at international and national levels.

**Health care information systems**

A reliable clinical information system was considered essential for NOA. A study of 59 GPs from the Nordic countries demonstrated that some valid data (relating to consultation rates, diagnoses, referrals and investigations) are available from electronic medical records in general practice. Morbidity networks, some using continuous morbidity recording, are running in many countries. However, the use of different software packages in most countries is resulting in incompatibility nationally and internationally. The meeting stressed the importance of clear numerators and denominators, and of data linkage between episodes, cases and diagnoses. Data held at the primary care level vary in quantity, content and quality in each country, as does local access to hospital utilization data.

**Multiple methods and data sources to define needs and outcomes of care**

Participants demonstrated that throughout Europe many methods and sources of data have been used to assess the need for and the outcomes of care. They noted that where centres were performing global needs assessment, each centre was using data from different sources to build up a more complete picture.

A small area study from the United Kingdom (Scotland) had outlined four methods or general sources of data. The centre in Belgium had outlined eight (more specific) sources, including health insurance data, surveys of the population, surveys of the providers, and specific registers which were locally appropriate. Methods used in primary care in Castelldefels (Spain) included data on prevention and health promotion, chronic disease management, and specific health status instruments applied in case management; it was hoped that a global needs assessment questionnaire for PHC would be developed. The value of quantitative and qualitative approaches was also illustrated to ensure community involvement in Manchester (United Kingdom).

**Strengths and weaknesses of different methods and data sources**

**Data held at the primary care level.** The advantage of this approach is that much information can be routinely available from computerized data, medical records, annual reports and financial statements. Much local knowledge of the neighbourhood is held by the team. In the United Kingdom this method has been shown to increase the coverage of cervical cytology, immunizations and asthma and diabetic care in the community following financial incentives to GPs. **Weaknesses** include that the data have to be cleaned and analysed. Practice data may underestimate the prevalence of disease in a community, and the preferences and perceptions of health professionals may not reflect the patients’ concerns.

**Routine local statistics** (including practice-specific hospital utilization and census data) give a descriptive account of morbidity and socioeconomic indicators and allow comparison with regional norms. Collaboration between public health and primary care allows sharing of perspectives and skills. However, such data must be interpreted carefully as demand and supply
often have more influence on hospital usage than need. Routinely collected data may be inaccurate, and discretion is needed to judge which data are the most useful. A few unusual events may skew very small area statistics. Census data relate to geographic areas rather than practice populations.

Public involvement methods such as interviews with patients, health forums, focus groups or rapid appraisal can encourage a broad multidisciplinary approach to assessing and meeting needs. A neighbourhood profile is generated which details needs and available resources and contains suggestions for change. Because people’s broad priorities are heard, health service interventions are weighed against other options to improve local quality of life. The process itself may facilitate change. However, coordination may be difficult, and the work is intense and time-consuming. Bias can occur where key informants are chosen from groups which share similar views about a problem and are not balanced by informants who may have different views. The outcomes of such methods which involve the community are particularly difficult to evaluate, but helpful formats exist.

Questionnaire surveys may yield detailed information about acute and chronic illness in the population, and the perceived need for existing and potential services both for users and non-users. The instrument could be reapplied to the same population or to a different population for comparisons over time or across areas. However, a low response rate may be a problem, especially in young men. The needs and service suggestions of the well majority may mask the responses of the neediest respondents. Clinicians and patients may understand words such as hypertension differently. Some instruments may not be sufficiently sensitive to document a small change in health status. Considerable time, resources and specific skills are required.

Levels at which to conduct NOA

The individual PHC team, which usually consists of one to eight GPs and a variable number of other members, is the building brick of primary care delivery. NOA has been successfully carried out at this level. Health service reforms in countries such as Belgium, Portugal, Spain, the United Kingdom (England and Scotland) and possibly some eastern European countries are calling for NOA at primary care level but with larger populations. Such denominators vary from about 40 000 to up to about 500 000 persons. In the United Kingdom (England) such groups are to be given management allowances to assess needs for primary and secondary care and to commission health care to meet these needs.

The workshop realized that meeting local needs may result in some inequalities in service provision according to local priorities and create ethical dilemmas. This should not stop attempts to meet the most pressing local needs.

At whatever level NOA is conducted, it is important also to consider how the findings compare with national priorities which may be quite different. For instance arthritis, dyspepsia and anxiety are the most frequent problems in primary care but have never been national priorities in the United Kingdom. As most funding comes from central sources, national priorities are easier to fund than locally derived ones, and this anomaly should be addressed.
Quality of care development (QCD)

Experience from Norway and from the European Quality Network suggests that the concept of quality of care development can help progress needs assessment to care provision and outcomes assessment. The first three steps of QCD are applicable to needs assessment:

1. identification of the problem
2. establishment of priorities, indicators, criteria and standards
3. collection of data
4. assessment of quality
5. feedback to providers
6. implementation of change
7. re-evaluation and quality monitoring.

The latter steps complete the circle. QCD utilizes cyclical data collection, benchmarking, identification of problem areas, interventions and, as part of the cycle, renewed benchmarking of indicators with feedback. Whereas NOA aims at “doing the right thing”, QCD focuses on “doing the thing right”. Used together they can “do the right things right”. The educational potential of clinical databases and guidelines is evident. Realistic measurable targets must be set to allow achievements to be demonstrated.

Networks

International comparative research is important for many reasons including national comparisons of health services input and output at national levels and at local levels within countries. This was illustrated by a paper from the WHO collaborating centre for PHC in the Netherlands. The practical difficulties of setting up a new network were described from the experience of the Tipping The Balance towards PHC network. These were language, funding, time commitment, differences in local priorities, agreeing and standardizing instruments, and training of researchers.

CONCLUSIONS

The working group concluded that needs and outcomes assessment is highly relevant for the further effective development of primary health care and for the strengthening of the broader concept of primary health care that looks into the social and physical conditions in which people live.

Current constraints and opportunities for NOA in Europe

The most significant constraints on NOA were considered to be centralization in the health service setting in some countries, the lack of time set aside for this work in most countries, a lack of financial incentives, a fear some GPs have of being controlled, professional resistance from academic, government and some hospital bodies, poor communications systems, incompatible information (software systems) and disease codings, no basic framework available of core information needed for NOA, potential tension between individual and population perspectives, lack of functioning teams in most countries, and lack of training of clinicians and managers in NOA and community involvement methods.
Opportunities at present include the fact that official policy support from governments and professional bodies is now evident to evaluate outcomes, and to involve the community in this process. There is a general increase in the expectations of patients/citizens and trends in empowerment. There is also a policy trend in several countries towards a focus on local populations for resource allocation purposes. Increased computerization and hence extractability and analysis of data are now possible. The quality of routinely available data is also improving.

**Conclusions concerning methodologies**

Methodologies for NOA in PHC should

- involve professional, patient and community perspectives in assessing needs and evaluating outcomes;
- involve all relevant PHC team members and also intersectoral collaboration;
- utilize a mix of locally appropriate quantitative and qualitative methods;
- consider multiple methods utilizing data from four general sources such as
  - databases at primary care level
  - other routine data such as census and hospital utilization data
  - a patient involvement/community participation initiative
  - a specific questionnaire survey of the population.

From each of the four general sources of data listed above, sets of specific indicators for measuring needs and outcomes would be very useful. These indicators should be potentially applicable to countries within western, southern and especially eastern Europe. Annex 3 lists as a starting point some summary indicators which have been found to be relevant and relatively easily obtained in the United Kingdom.

Moreover, NOA in PHC is necessary at two levels: individual practice and district, and can use a global or disease-specific approach at each level. Cooperation with the community adds to the validity and impact of the process. Resources and training are prerequisites, as mentioned above.

Issues relating to research and development, to the funding of this type of initiative, and to general implementation of changes are relevant. Outcomes assessment is less developed than needs assessment. The processes of continuous quality care development, audit and guideline implementation may help progress needs assessment to quality care provision and outcomes assessment.

However, a most important element in all this is the PHC worker. The prerequisite for success of NOA will be the proper training of PHC staff in the skills and thinking required in NOA.

**Recommendations**

The workshop felt that WHO should have a leading role in the development, advocacy and facilitation of a sound practical approach to NOA in primary care. Participants made the following specific recommendations.

1. The secretariat should collected further examples of good practice from other centres and especially any practical guidelines for NOA developed in specific centres and countries.
2. Group members should communicate their detailed methodologies for projects they were running so as to promote a uniform methodology (if possible). All centres represented are potentially voluntary partners for implementing a common approach utilizing both professionally defined and community perceptions.

3. From each of the four general sources of data, sets of specific indicators for NOA should be identified within western, southern and especially eastern European countries, utilizing primary care, public health and intersectoral and community collaboration, and tested by the workshop participants and others internationally. An inventory of useful core data, specific health surveys, and methods of community involvement relating to NOA should be collected.

4. A European practical guide to local NOA should be produced to help GPs in all countries to assess needs systematically and to evaluate outcomes during their everyday work. This would include practical tools and methods and other relevant material to help local teams in different countries carry out NOA.

5. A research and development effort to look into issues of management and funding of such initiatives is necessary.

6. Training should be organized for PHC staff for critical skills required in NOA. For this, the application of new telecommunication technologies could be explored and used to improve accessibility.

7. The formation of a formal network at this stage is not necessary, but the Workshop should mark the beginning of a process of exchanging experience and information about developments in other countries. WHO may wish to develop model action research centres especially to help the development of centres in eastern Europe.

A follow-up meeting organized by WHO should be planned to encourage informal networking and review of recommendations.

**BIBLIOGRAPHY**


Annex 1

WORKING PAPERS AND BACKGROUND MATERIAL

Working papers

DLVR 01 01 01/1 Provisional list of working papers and background material
DLVR 01 01 01/2 Scope and purpose
DLVR 01 01 01/3 Provisional agenda
DLVR 01 01 01/4 Provisional programme
DLVR 01 01 01/5 Provisional list of participants
DLVR 01 01 01/6 Needs and outcomes assessment in the context of the programme of the WHO Regional Office for Europe, by Dr Anastas E. Philalithis
DLVR 01 01 01/7 The relevance of needs and outcomes assessment for other WHO regions, by Dr Dan Makuto
DLVR 01 01 01/8 Methodologies used in needs and outcomes assessment (NOA), by Dr Scott A. Murray
DLVR 01 01 01/9 The conditions for implementation of needs and outcomes assessment, by Dr Pertti Kekki
DLVR 01 01 01/10 Community-oriented primary care (COPC) case study of multidisciplinary cooperation in population-based approaches – Why? What? Who? How?, by Dr Nurit Wagner
DLVR 01 01 01/11 -
DLVR 01 01 01/12 Needs assessment in primary health care: The experience of Castelldefels Health Centre, by Dr Joan Gené Badia
DLVR 01 01 01/13 Patients, diagnoses and activities in general practice in the Nordic countries, by Dr Anders Grimsmo (Hagman, Lorentzen, Matthiessen and Njalsson)
DLVR 01 01 01/14 Needs and outcomes assessment in primary health care: Experiences gained from Crete, Greece, by Dr Christos Lionis
DLVR 01 01 01/15 An overview of needs and outcome assessment in Belgium, by Dr Leo Pas
DLVR 01 01 01/16 Health needs and the health care reform in Portugal, by Dr Victor Ramos
DLVR 01 01 01/17 Needs and outcome assessment in the population health programme of Östergötland, Sweden, by Dr Eric Trell
DLVR 01 01 01/18 Manchester, United Kingdom – Inner City Hard-To-Reach-groups (an example of the Somali community): Methods for developing and matching community defined health needs with health care development, by Dr Hermione Lovel, Dr Rhetta Moran and Ms Zainab Mohammed
DLVR 01 01 01/19 A community health approach to reducing substance abuse, by Dr Janice Ford Griffin
DLVR 01 01 01/20 Ms C.B. Morris
DLVR 01 01 01/21 Common features of quality of care development and needs assessment, by Dr Harald Bergrem
DLVR 01 01 01/22 Tipping the balance towards primary health care (TTB) – a European research network in primary care, by Dr Chris Buttanshaw
Background material

EUR/ICP/PHC 340


Local provision of care according to needs, by Dr Eric Trell, Sweden, 1992.
Annex 2

COMMUNITY-ORIENTED PLANNING AND EVALUATION CYCLE (COPEC)

Integrating primary health care with continuous quality development

Why?
- Costs and resources
- Different needs
- Ethics

How?
- Surveys
- Routine data
- Other information (informatics)

By?
- Government
- Ministry of Health
- Insurers
- Care-givers
- Community

Needs Problems

Capacity assessment
- Partnership
- Self-care
- Empowerment
- Multidisciplinarity
- Outcome assessment

Quality

Research and Development:
- Standards
- Evaluation
- Benchmarking

Individual Family

Community
Annex 3

POSSIBLE METHODS AND INDICATORS FOR ASSESSING NEEDS AND OUTCOMES

Method 1: Collect primary care-based clinical and management information

- Age and sex profile in 5-year bands, males and females
- Prescribing details
  - repeat prescribing rates from practice computer
  - collated prescribing figures, if available
- Prevalence of some specific chronic disease, e.g. ischaemic heart disease, COAD, asthma, epilepsy, psychosis, thyroid disease, hypertension and diabetes
- Data from practice payment details:
  - percentage of patients attracting deprivation payments
  - family planning uptake
  - temporary resident
  - obstetric care and other item-of-service payments
- Health promotion and disease prevention data
  - smoking, alcohol consumption, substance misuse, BMI data
  - immunization coverage levels (2- and 5-year-olds)
  - cervical cytology coverage
- Contacts with GPs
  - surgery consultation rate per 1000 registered patients per year
  - house call rate per 1000 registered patients per year
  - out of hours visits per 1000 registered patients per year
  - telephone advice per 1000 registered patients per year
- Contacts with other members of PHC team
  - practice nurse contacts per 1000 registered patients per year
  - health visitor contacts per 1000 registered patients per year
  - district nurse contacts per 1000 registered patients per year
- Knowledge (mostly implicit of the PHC team) of local health needs
  - health visitor: practice profile, breastfeeding rates, use of other agencies
  - district nurse: workload details, observations in patients’ homes
  - practice nurse: workload details, e.g. influenza coverage rate
  - receptionists: patients’ perceptions, availability of appointments
- Deaths: causes, places of death, preventable factors
- §Turnover of patients
- Other sources (suggestions box, patient participation group).

If reliable data (e.g. use of investigations, referrals) are available from other sources, use them rather than duplicate work in the practice for the following:

- use of investigations (per 1000 registered patients per year, individually) for bacteriology, virology, haematology, biochemistry, radiology, ECGs
- referrals to physiotherapy, chiropody, occupational therapy per 1000 registered patients per annum.
Method 2: Gather hospital, community trust and census data

In each case a direct comparison with local and regional figures gives added understanding. Different data may be more relevant in other neighbourhoods with different local needs; this list is a point of departure.

<table>
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<th>Statistics</th>
<th>Most useful variables</th>
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| 1. Inpatient data | • Ten most frequent diagnoses made at hospital inpatient discharge (rates per 1000 registered patients), tabulated in descending order\(^a\)  
• Elective admission (rate per 1000 registered patients)  
• Non-elective admission (rate per 1000 registered patients)  
• Average mean waiting time (days)  
• Ten most frequent day case diagnoses per 1000 patients, tabulated in descending order of frequency for each practice  
• Top three day case procedures per 1000 patients, in descending order of frequency |
| 2. Outpatient data | • Outpatient referral rate per 1000 registered patients  
• Referral rates for five most frequent specialties, tabulated in descending frequency for each practice  
• Mean waiting time in days  
• Attendances at the accident and emergency department per 1000 registered patients |
| 3. Obstetric data | • Births (rate per 1000 registered patients) |
| 4. Community data | • District nursing visits per 1000 patients per year  
• Health visitors, visits and clinic attendances per 1000 patients per year |
| 5. Investigations | • Use of investigations (per 1000 patients per year) for bacteriology, virology, haematology, biochemistry, radiology, ECGs |
| 6. Referrals | • to physiotherapy (per 1000 patients per year, clinic and domiciliary)  
• to chiropody (per 1000 patients per year, clinic and domiciliary)  
• to occupational therapy (per 1000 patients per year) |
| 7. Census\(^b\) | • Percentage of residents with limiting long-term illness  
• Demographic profile, in 5-year bands  
• Unemployment rates, male and female (%)  
• Percentage of house owners  
• Percentage of car owners  
• Percentage of households with lone parents |

\(^a\) The ICD-10 codes to three digits are recommended, transfers are excluded and patients with multiple discharges from the same hospital, using the same facility and with the same diagnosis are counted only once.

\(^b\) The census data relate to residents of a small area, not patients registered with a specific practice.

Method 3: Gaining public involvement

Focus groups

Focus groups are facilitated discussion groups which allow members of the target population to express their ideas in a spontaneous manner that is not structured by the researcher’s predetermined ideas. They can give useful insights into perceived needs, quality of services, and understandings of health issues. They can raise issues which are important to patients but do not give quantifiable information. Initial training is required to facilitate focus groups, and a variety of different groups may be necessary to be representative in some situations.
Practical points

- The optimum size for a group is 8–12 participants.
- The facilitator introduces topics for discussion.
- Proceedings are recorded using a tape recorder and later transcribed, in full or in note form, preferably by another facilitator.

Rapid appraisal

A team, which should ideally be multisectoral in composition, gathers data about needs, priorities for change and resources in the area under study from:

- interviews with key informants (individuals with knowledge of the community through their jobs or social positions) and patients;
- available documents about the neighbourhood/community;
- observations made inside homes and in the neighbourhood.

Practical points

- Use the framework of an information pyramid to guide data collection and analysis.
- Collate the perceived needs, priorities and community-perceived solutions (target outcomes) for each box of the information pyramid.
- Consider facilitating change in primary care services, commissioning of secondary care, and local advocacy to improve wider determinants of health

Method 4: Undertake (or use an existing) questionnaire survey

Surveys to assist local NOA and resource allocation must be modestly defined and use a mixture of lay and medical concepts. Questions concerning the following areas may be especially relevant:

- acute illnesses and experience of common symptoms
- use of health services over the last 6 or 12 months
- patient satisfaction
- perceived need for existing and potential services
- specific concerns and worries which may affect health
- consider the addition of a general health status instrument (e.g. SF36, SF12) to the questionnaire
- consider a disease-specific instrument
- specific questions for people with specific long-term health problems or carers
- chronic illness\(^1\)
  - any long-term illness
  - several marker conditions (e.g. hypertension, back pain)
- social and demographic characteristics\(^1\)
  - car or house ownership
  - unemployment.

Consider checking a sample of medical records from non-respondents.

\(^1\) May not be necessary if data obtained already.
Annex 4

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