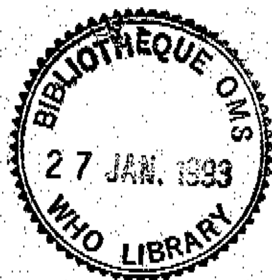
EUR/ICP/PHC 340

NEEDS ASSESSMENT IN LOCAL AREAS AND ITS CONSEQUENCES FOR HEALTH CARE PROVISION



WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE
COPENHAGEN

TARGET 30

COMMUNITY SERVICES TO MEET SPECIAL NEEDS

By the year 2000, people in all Member States needing long-term care and support should have access to appropriate services of a high quality.

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EUR/ICP/PHC 340
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ORIGINAL: ENGLISH

NEEDS ASSESSMENT IN LOCAL AREAS AND ITS CONSEQUENCES FOR HEALTH CARE PROVISION

Report on a WHO meeting

Jerusalem
27–30 October 1991

1992

EUR/HFA target 30

ABSTRACT

Primary health care can meet the needs of the population in an equitable way only if these needs are known. The WHO Regional Office for Europe convened a Working Group to examine the consequences for primary care of the assessment of the health needs of the population at the district level. The Group discussed a useful model for community-oriented primary care (COPC), which involves the delivery of programmes tailored to community needs. The participants considered needs assessment as the basis for allocating resources, prioritizing the needs for community health programmes, and planning and evaluating these programmes; in the third area, they stressed the need for further development of the model for a community-oriented planning and evaluation cycle (COPEC). Finally, the Working Group made recommendations on: the dissemination of information on community health needs and programmes to primary health care staff, the needs of these staff for training in needs assessment and COPC, and the role of WHO in encouraging the further development of COPC.

Keywords

FAMILY PRACTICE
ALCOHOLISM – prevent/control

CONTENTS

	Page
Introduction	1
Discussion	1
Resource allocation	3
Appraisal of needs for community health programmes	5
The planning and evaluation of community health programmes	7
Recommendations	9
Annex 1 List of participants	11

INTRODUCTION

The Working Group on Health Needs Assessment and Its Consequences for Primary Health Care met in Jerusalem from 27 to 30 October 1991. The Group was convened by the WHO Regional Office for Europe in collaboration with the Ministry of Health in Israel. The participants are listed in Annex 1.

One of the fundamentals of primary health care is the provision of care based on the principle of equity and the needs of the population. This requires an assessment of the health status of people living within a particular area. The Working Group was asked to focus on the assessment of the health status and needs of populations in districts or their local equivalents. The importance of identifying the methods used for such an assessment was stressed, as these methods may differ from those used at central level or their use may not necessarily reveal the people's health needs; that depends on who determines the needs and on what grounds. Thus, involving consumers and taking account of their demands are particularly important at the district level. Proper use must therefore be made of epidemiological approaches, and the results of the provision of care in the community must be borne in mind. Assessments are of course particularly necessary for high-risk and vulnerable groups, since they need special attention and approaches to the provision of care. The Working Group was therefore asked mainly to consider the position of disadvantaged groups and not the great variety of medical risk groups.

The Working Group was also charged with the task of identifying ways to make better use of the results of needs assessment and to consider a strategy for targeting health care provision according to the priorities identified through such assessments. To this end, the Group was asked to review local health service initiatives and to consider proposals for future projects covering care provided by general practitioners.

DISCUSSION

In its discussion, the Working Group began by examining:

- the concept of community-oriented primary care;

- examples of organizing primary care according to needs in the United Kingdom;
- experience with the value of a health for all strategy in promoting primary care in Istria district, Croatia; and
- the approach used to care for disadvantaged groups in Israel.

In particular, community-oriented primary care (COPC) is the practice of primary health care, combining care of the community with care of individuals and family. A central feature is the development of community health programmes with defined objectives and activities, designed to deal systematically with major health needs of the community. These programmes, which are integrated into the care of individuals and families, can vary widely in subject and aims. Many studies have demonstrated the effectiveness of COPC. In Israel, for example, the results of a broad COPC approach to disadvantaged groups in an urban region included a decrease in infant mortality, which fell to a rate equalling the regional average. Further, although this approach can lead to financial savings, it will not necessarily pay its own way, particularly if programmes are not directed towards working populations.

A number of issues need to be addressed in developing COPC. The community to be addressed can be defined in a number of ways. The basis for programme development is the epidemiological picture in the community, together with information on the needs expressed by the community. The latter
should always be taken into account, in conjunction with objective data. The information collected has two primary functions as a basis for: the selection, prioritization and development of appropriate programmes, and for the monitoring and evaluation of such programmes. It is vital to ensure that the information is appropriately linked to the development and appraisal of programmes. In planning a programme, objectives need to be defined, activities planned and provision made for monitoring and evaluation.

In the preliminary stage, when the purpose is to get to know the population and identify health problems meriting special study, information obtained from people living and working in the community, and other easily accessible information, may be very

helpful. In general, a more detailed epidemiological inquiry into selected problems (a "community diagnosis") will later be required. While routinely collected data may supply sufficient information for identifying problems and priorities for action, data specific to the local population is definitely required for programme planning, monitoring and evaluation, and resource allocation.

The Working Group was divided into three smaller groups; they were asked to suggest general frameworks for targeting health care provision by general practitioners and primary health care teams that could be used under various conditions, mainly in the countries of central and eastern Europe. This initiative would be part of EUROCARE, one of the major projects of the Regional Office, which deals with health service issues in these Member States. The groups were also asked to identify ways in which district health services could function at a time of increasingly limited resources and continuing changes in society and thus in health care systems. Finally, the groups were asked to consider mechanisms for incorporating of health needs assessment into the formulation of primary health care programmes. They considered needs assessment as a basis for:

- resource allocation
- appraisal of needs for particular community health programmes
- the planning and evaluation of such programmes.

Each group was asked to consider mechanisms for translating ideas into action. They were to pay special attention to the issue of using existing data sets and the need for new data collection, examples of relevant projects and lessons learnt, anthropological methods and the involvement of the community.

Resource allocation

Resource allocation can be considered on a national, regional, district or subdistrict level. One group mainly considered the first two levels. Measurable needs were principally considered; felt and comparative needs were considered only briefly.

Generally available, routinely collected demographic data are sufficient of resource allocation. These data could cover, for example:

- children under 6 years
- children and adolescents aged 6 to 17 years
- adults aged 18–60
- women of childbearing age
- elderly people (over 60 years).

This practice has the advantage of being readily applicable throughout the Region. Mortality statistics are also widely available, and may be helpful, but morbidity statistics are more difficult to obtain. Special problems (such as a poliomyelitis outbreak) can attract special resources. The utilization of health services is another key factor that should determine resource allocation and information on issues such as waiting times and immunization rates may be easy to obtain. Indicators of the availability of health resources (such as the doctor/patient ratio and the hospital beds/population ratio) should be taken into account.

Decisions on resources are largely a matter of modifying existing budgets, rather than creating new ones. In addition, resource allocation is affected by whether a fixed or open budget structure is used. A mixture of private and public sector funding gives more flexibility.

Managerial decisions are often crucial in decisions on resource allocation, although managers may not have direct information on needs assessment. How managers make decisions needs to be understood; needs assessment is unlikely to be the only or even the major factor in decision-making. For example, managers in Spain are extensively lobbied by a wide variety of districts, each claiming to have special needs.

Factors affecting policy decisions include:

- ideals
- political ideology and pressures
- budget constraints
- citizen demands
- health professionals' demands
- academic opinion.

Governments tend to make provision for general standards, the quality of care and underprivileged and special populations. Governments should recognize the importance of health promotion and issues of equity. Equity was defined as
equal opportunities for access and treatment for all people with similar problems. Usually, there is a "basket" of services to which all citizens have access; the services should be available and acceptable to all. Ensuring this may involve the formulation of special programmes for underprivileged groups and, in some cases, intervention in such areas as education and employment.

Appraisal of needs for community health programmes

Another group identified the difficulty of obtaining appropriate information, citing "Finagle's law":

> The information you have is not what you want.
> The information you want is not what you need.
> The information you need is not what you can obtain.
> The information you can obtain costs more than you can pay.

The group considered the range of methods for acquiring the information needed to permit appraisal of the needs for a particular community health programme. This can often be done with information much simpler and more easily accessible than that required for detailed programme planning or evaluation. On the other hand, such information may not provide a sufficient basis for the definition of specific programme objectives and activities, and it will seldom constitute an adequate baseline for an evaluation.

In general, determining the current major problems is relatively easy. Problems may initially be identified through people's knowledge about the community, readily available records or reports on the community's health, the needs expressed by community members, or epidemiological data on a larger region or on similar communities.

Appraising the case for action, however – the justification for programmes to deal with the problems identified – is less easy. For

each problem, consideration should be given to three factors. The first is the importance of the problem. Determining this requires information on the nature, extent and impact of the problem in the community, general knowledge about the effects of the disorder or risk factor under consideration, and knowledge of the community's attitudes. Part of this information may be already available, and part may have to be sought. Information on the community is desirable, even if problems and programme objectives are defined centrally (in the form of national health targets, for example), since adaptation to local circumstances may be important. Second, the feasibility and cost of an appropriate programme should be considered. This requires knowledge about the availability of trained personnel, facilities and other resources. Third, the effectiveness of the intervention, should it be implemented, should be predicted. This may require an appraisal of local factors that may influence effectiveness.

The fewer the resources, the more important it is to establish priorities based on the competing demands. One suggested approach to prioritization is to use a score calculated by adding ratings of each of the three factors. The importance of each problem, for example, may be rated as low (1); moderate (2); or high (3). Feasibility and cost may be rated as low feasibility and high cost (1); intermediate (2); or high feasibility and low cost (3). Predicted effectiveness may be rated as low (1), moderate (2) or high (3). The scoring system has arbitrary features: the subjectivity of ratings and the equal weight given to each component. Nevertheless, using it may draw attention to important determinants of the case for action, and may facilitate the comparison of competing problems or alternative programmes directed at the same problem.

Methods of acquiring the information needed for determining the presence or importance of a problem include: discussions with professionals and community members, home visits and field observations, the use of census data and other readily available reports and statistics, the analysis of easily accessible records (clinical records, death certificates, etc.), simple demographic or health surveys, and more detailed epidemiological inquiries. One important technique is the analysis of information (examination results, responses to

questions, diagnoses, etc.) collected in the course of clinical care. This may include information collected for epidemiological purposes.

A case can be made for the routine collection of a standard set of basic data, particularly as part of the preliminary appraisal of a community. Owing to limits on time and resources, selectivity is essential; it may sometimes be advisable to concentrate on data concerning a particular part of the practice. The basic data set might include: demographic data and general information about the community, information about services, their utilization and the community's involvement in its own health care, and data on health and disease status, risk and protective factors, risk markers, and health-relevant knowledge, attitudes and practices.

The feasibility of collecting such information may be increased by the use of rapid epidemiological assessment techniques: relatively simple, undemanding and cheap methods of epidemiological assessment that can be readily applied when resources are limited, even though allowances may have to be made for limited accuracy and inherent bias. Such methods include rapid ethnographic assessment (the use of unstructured interviews and other anthropological methods), sentinel surveillance (reporting of infectious diseases in convenient but not necessarily representative sentinel groups), and the use of cluster samples (such as total households or groups of children living close to one another) to ease access to subjects in surveys.

The planning and evaluation of community health programmes

The third group listed the recognized steps of quality assurance:

(*a*) describing
(*b*) selecting
(*c*) analysing
(*d*) plannning
(*e*) targeting
(*f*) action
(*g*) follow-up.

These steps should not be taken as a straight line but as a continuous cycle, with reinforcement and upgrading all along the way. The group concluded that COPC is a useful model that can be adapted to particular circumstances. The group composed the designation community-oriented planning and evaluation cycle (COPEC) for the desired approach to programme planning and evaluation.

The assessment of needs as a basis for the planning and evaluation of a community health programme has three main parts. The first is content. The first question concerns the subjects suitable for quality control and management. In other words, what types of need are encountered? Surely one should ask whether there is a constructive taxonomy or "shopping list" of the needs of various groups, which can be expressed as targets, markers or performance indicators. The group felt that this idea needed more elaboration.

The second aspect, process, is simpler to grasp. An evaluation should describe not only how well a programme is carried out but also how well it was originally defined and designed. The consideration of process thus includes decision-making and priority setting.

The third aspect, technology, is perhaps the most overlooked. Everybody agrees that technology includes both hard- and software, the former currently being the personal computer. Does specially designed software for planning and evaluation exist however; if so, how should it be utilized? Although this requires further consideration, the group agreed to make an information system the hub of COPEC, anticipating a stage at which the system would function automatically. Among other things, this would require that the system and the cycle share terminology and subject areas. This points to a need for a core data set.

Further, technology includes methodology, and thus a scientific approach to and standards for programme planning and evaluation. Basically, community health programmes are a form of research in action and do not need internal control groups. Nevertheless, the evaluation must in certain respects be independent from the programme, although maintaining contact with it, to supply feedback and support in making modifications.

The group felt that all three aspects of needs assessment as a basis for planning and evaluation – the content, the process and the technology – required further elucidation. Even so, the COPEC model was tested on a theoretical basis, for its usefulness for programmes on three types of health problems, with varying degrees of primary health care involvement. These were programmes on:

- accidents (with primary health care as only one of the partners);
- cancer and cardiovascular disease prevention (with primary health care working with hospital and organ specialists); and
- care for the elderly (with primary health care having the main responsibility).

It is perhaps not surprising that COPEC, given its firm basis on COPC, was found to work well in all three areas. Further, the group found that the model could be useful in widely divergent health care systems and programmes: from the prevention of drunken driving in Bucharest and of cardiovascular diseases in Prague to action against childhood accidents in Arab communities in Israel.

COPEC was currently a theoretical construct at the prototype stage. It needed a good deal of refinement and practical testing. Nevertheless, it could be worth while and cost-efficient to follow it up; it has the advantage of direct descent from scientifically well substantiated forerunners, apart from having several parallels in industry and management. These factors – along with public interest in and expectations of the health services, and the importance of work for health for all at the decisive grassroots level – increase the need for modern quality assurance and control instruments for community health programmes.

Recommendations

1. Information on community health care programmes and projects should be widely disseminated to and discussed by providers of primary health care.

2. Information on local needs should be made readily available for circulation and discussion among providers of primary health care.

3. Academic departments of public health medicine should take part in the education, training and support of primary care staff at all levels.

4. All primary care staff should receive training and continuing education in needs assessment and COPC, preferably including hands-on experience.

5. Governments, regions and districts, national professional organizations and other relevant organizations should be involved in postgraduate training and continuing education and actively encourage the involvement of primary care staff and general practitioners in needs assessment and COPC. WHO should encourage these organizations to carry out activities to promote this development.

6. The COPEC model for the planning and evaluation of primary health care projects should undergo further piloted-testing in a variety of settings.

7. WHO should seek clarification from countries of the planned role and tasks of disease prevention and health promotion services, and offer to sponsor the establishment of one or more COPC projects in different countries.

8. WHO should reiterate to countries the advantages of prevention and the need for education and training within primary health care, and should encourage countries to establish and allocate resources to at least one centre for the development and evaluation of needs assessment and COPC.

9. Where primary health care teams are not well developed, WHO should consider sponsoring the establishment of networks and/or cooperatives of individual care providers to assess needs and develop local programmes.

Annex I

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