

Economic evaluation in health: a thumb nail sketch

D P Kernick

Health economics uses traditional economic theory to consider problems in health care. Although health economics can be applied at a number of levels, including analysis of the demand for health care, planning and budgeting, monitoring and evaluation, it is economic evaluation of treatments that will be of most interest to doctors. Against a background of increasing demands on limited health resources, economic evaluation helps decision making by considering the “outputs” of competing interventions in relation to the resources that they consume (figure). To address these issues, relevant outputs must be defined, costs measured, and studies relating outputs to their costs undertaken.¹

Doctors will be presented with increasing numbers of economic studies relevant to all aspects of health care. All studies will have the same basic constructs. Here, simple analysis of the title page and summary of a published paper on ramipril in heart failure (reprinted in the box) is used to highlight issues to be borne in mind when assessing economic evaluations in health. Points at issue are italicised and numbered in relation to subsequent annotations.

Annotations in economic evaluation

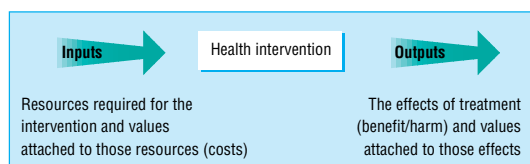
The numbered points in this section refer to the box on p 1664.

(1) Publication bias

Economic studies are often commissioned by agencies that have an interest in the outcome. In one study of publication bias, 89% of evaluations supported by pharmaceutical companies favoured new drug treatment over control treatment, compared with 61% of drug studies supported by other means.² Publication bias is, therefore, a particular problem in the area of pharmacoeconomics.

(2) Type of analysis

There are four main types of economic analysis in health:



Economic evaluation relates outputs of competing interventions to the resources consumed

Summary points

Economic evaluations utilise economic theory to facilitate choice between competing health interventions when resources are scarce

Guidelines for the conduct of these studies exist, but disagreement over methodology and inherent problems in many areas, such as valuation of human life and wellbeing, remain

A working knowledge of the subject is essential if those delivering health care are to understand its benefits and pitfalls

- Cost minimisation—here only inputs are compared; outputs are assumed to be equal, which is rarely so
- Cost benefit—in this type of analysis all outputs are measured in monetary terms³
- Cost effectiveness—measures a clinical output, such as morbidity, reduction in blood pressure, or quality of life.⁴ Cost effectiveness analysis has generally superseded cost benefit analysis because of the problems of allocating monetary values to all outputs. The example relates cost to a clinical measure—life years gained
- Cost utility—allocates a quality of life value (between 1 (perfect health) and 0 (death)) and combines quantity and quality of life to derive the quality adjusted life year (QALY).⁵ Although the cost utility method has the advantage that different interventions can be compared across a broad range of choices in resource allocation, a number of methodological problems remain.

(3) Relating costs to outcomes

Costs must be related to outcomes. Ideally, economic analysis should be undertaken alongside controlled trials, but this will not always be possible. In the study illustrated, retrospective analysis of a published randomised controlled trial was undertaken using cost data obtained from a separate study. Where clinical data are not available, economists often develop models that analyse the probability of events (decision tree analysis), using data where these are available and expert opinion where they are not.⁶

(4) Time scales

With regard to study duration, certain aspects have to be balanced. The length of follow up has to be long enough to capture all the clinical outcomes, while

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Cost effectiveness in the treatment of heart failure with ramipril. A Swedish substudy of the AIRE study

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Summary

We estimated the *cost effectiveness* (2) of adding the ACE inhibitor ramipril to conventional treatment in patients with heart failure after acute myocardial infarction. These estimates were *based on* (3) the Acute Infarction Ramipril Efficacy (AIRE) study and on complementary Swedish healthcare resource use data for a subset of patients. The average follow up period (4) was 15 months (minimum 6 months, maximum 3.8 years). *The perspective* (5) of the analysis was that of the county councils (third-party payers), and we focused on *the cost of drugs and hospitalisation* (6). *The marginal cost effectiveness* (7) of the treatment was estimated over 3 treatment periods: 1, 2 and 3.8 years. The cost effectiveness ratios varied between SEK14 148 and SEK33 033 *per life year gained* (8) (\$US1 = SEK7.70, £1 = SEK12.40) for the 3 treatment periods. Adding ramipril to *conventional treatment* (9) for heart failure after acute myocardial infarction is therefore cost effective, and *compares favourably* (10) with the cost effectiveness of other common medical therapies in the cardiovascular field.

(Reproduced with permission from *Pharmacoeconomics* 1997;12:256-66.)

results must be available within a reasonable period of time. And the resource implications of the study itself have to be considered. As we prefer to incur benefits sooner and costs later, for studies lasting more than a year calculations need to be made to compare interventions within the same time frame—they need to be discounted.⁷ However, agreement over a suitable discount rate and whether benefits should be discounted has yet to be achieved.

(5) The perspective

Economic data can be analysed from the viewpoint of the pharmaceutical company, the individual patient, the general practice, the health authority, the NHS, or society, and different answers may be obtained from different perspectives. Data should be presented in such a way that the study can be analysed from any perspective, although health economists will generally adopt a societal perspective.

(6) Validity of cost measurements

There is wide variation in estimates of unit costs across the NHS. This reflects uncertainty in methodology rather than differences in efficiency. Caution should therefore be exercised when prices are used as a proxy

Questions to ask about an economic study

- Are all the relevant alternative treatments considered?
- What is the viewpoint or perspective of the study, for example society, the NHS, the purchasing authority, the general practitioner?
- Were the economic data collected alongside a trial, applied retrospectively to an existing trial, or modelled?
- Are all costs measured and sources of costs credible?
- What output measures were used?
- Are the results generalisable, particularly to your practice?

for costs. The NHS is not a “perfect” market and costs and prices are rarely interchangeable. Direct costs are those arising directly from the intervention, such as drug and medical costs, while indirect costs include economic costs to the patients such as loss of earnings while in hospital. “Intangibles” are items of unknown value, such as loss of leisure time or loss of life, that may require to have a monetary value placed on them in any economic analysis. When uncertainty exists over the accuracy of data, a sensitivity analysis can be used to test the conclusions of a study against the range of values that are likely to occur.⁸

(7) Importance of marginal analysis

Decisions in health are not usually about whether to provide a service or not, but whether to expand or contract a particular intervention. Health economists stress the importance of marginal analysis—the incremental benefit obtained from an increment in cost—rather than average cost and benefit ratios in decision making.⁹

(8) Measuring the outputs

It may be difficult to identify all the benefits and disadvantages of an intervention.¹⁰ Measurement of mortality is the simplest approach, and is used in the ramipril study exemplified in terms of extra years of life gained. Life years gained is an absolute measure rather than a surrogate measure. Surrogate measures—for example, a reduction in left ventricular size as a result of treatment—are often used for practical reasons to infer final outcomes of interest. The measure, life years gained, however, gives no information of the quality of life in those additional years.

(9) Which comparator?

Ideally, a study should compare all competing interventions, including doing nothing. The study illustrated compares a new treatment, ramipril, with existing treatment only, and assumes that the existing treatment has been proved to be effective.

(10) External validity

This study was undertaken in Swedish patients, using Swedish cost data, and from the point of view of the Swedish purchasing authority, the county council. What does it mean to British patients and a British general practice?

Conclusion

Clinical decisions will be directed increasingly by considerations of both effectiveness and cost effectiveness between competing interventions. Although guidelines for the conduct of economic studies exist, lack of consensus in many areas of methodology and inherent problems with valuation of human life and wellbeing remain.¹¹

In the final analysis, decisions will not be directed by economic studies alone but will be integrated within value systems that include considerations of equity, empowerment, and political direction. Health economics is not an exact science. A working knowledge see box “Finding out more”) of the subject is essential if those delivering health care are to understand its benefits and pitfalls. Some of the questions that should be asked are listed in the box.

Finding out more**Useful resources**

- Office of Health Economics, 12 Whitehall, London SW1A 2DY (tel 0171 930 9203)
- The NHS Economic Evaluation Database. NHS Centre for Reviews and Dissemination, York YO1 5DD (tel 01904 433707). Free access to the database on <http://www.york.ac.uk/inst/crd/info.htm>

Introductory texts

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Conflict of interest: None.

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Managing demand

Matching demand and supply fairly and efficiently

David Pencheon

The challenge of meeting the demand for public services that are free at the point of use is increasing. Examples, in increasing order of complexity and controversy, include water, higher education, road space, and health care. These services are perceived as important to society in general, and demand is rising rapidly and unsustainably.

Such increases in demand can be managed either by reducing the demand—for example, by charging, as for water or road space—or by increasing the supply—for example, via increased funding, as with student loans. In health care, perversely, we do the opposite of both these approaches: we fuel demand by failing to manage it—for example, by not curbing expectations—and we are often forced to cut supply through lack of resources.

Demand for health care is undoubtedly rising. The average number of consultations for children in each of the first years of life (even after excluding surveillance and immunisations) has, in one general practice, risen from 3.73 per child in 1960 to 17.2 in 1990.¹ We need to understand better how this ever increasing demand for health care is initiated and expressed and use this understanding to manage the whole system better. Professionals have the same increasing expectations from the service as the public does. Managing the pressure on the health service is as much about managing the expectations and rights of professionals to treat as it is about managing the expectations of patients to be treated.

To many, managing demand for health care sounds like a euphemism for rationing via restricting supply. However, it is a broader approach: the consumption of any product or service is determined by the relation between supply and demand, and different tools are used to influence supply and demand. Historically, supply management has been the most potent tool in

Summary points

Demand management is about moving from merely struggling to meet the increasing demand for health services to shaping this demand so that health needs of individuals and populations are best served with the available resources

Managing demand does not only mean reducing it: where cost effective health care is underused, demand may need to be encouraged

The potential exists to develop more graduated access to health care

One important way of managing demand is to supply and clarify simple knowledge and advice

It may be possible to meet demand in different ways

Opportunities and incentives need to be provided for people to meet their perceived needs in ways that supplement formal health care

This is the first of five articles on ways of managing demand for health care

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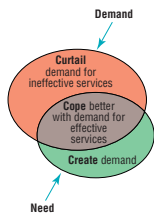
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coping with the challenges in health care. In the past 15 years this has been supplemented by processes for assessing need.² We now need to add demand management to these approaches.

What is demand management?

Demand management is the process of identifying where, how, why, and by whom demand for health care

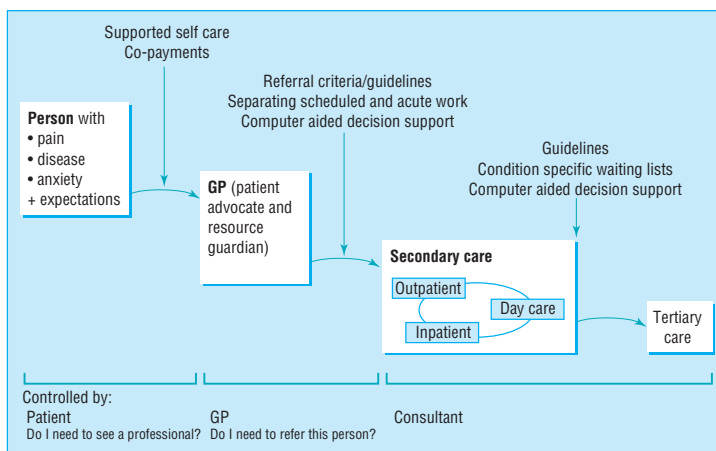


is made and then deciding on the best methods of managing this demand (which might mean curtailing, coping, or creating demand) such that the most cost effective, appropriate, and equitable health care system can be developed. Critically, it depends on understanding how the behaviour of those who express the demand—citizens and professionals—is changing. It is concerned with making more appropriate use of the health services (not necessarily reducing it or making it cheaper). More specifically, demand management “is the support of individuals so that they may make rational health and medical decisions based on a consideration of benefits and risks.”³ This definition comes from North America, where managing demand is an established discipline.

The many causes of a demand for health care need a variety of responses. For instance, some pressures may be best met, not by curtailing demand but by coping with it and meeting it in a radically different way. Recent examples include the use of helplines as a first point of access to health care in the home.⁴ The assumption that better informed people demand ever more health care may be unfounded. Studies of interactive information sources that allow patients to understand the advantages and disadvantages of prostate surgery show that increased information may persuade some people to avoid surgery.⁵ In a country with relatively high activity levels, such as America, this has been shown to reduce activity by up to 40%. In countries with lower activity rates it is not clear that the proportionate decrease would be the same,⁶ although it is important to find out.

Where is demand expressed?

The figure shows the way in which people travel through the healthcare system. Most healthcare needs are met without recourse to formal healthcare services, so a vital part of demand management is supporting this self care. Similarly, most problems presented to primary care are dealt with without referral. Again, efforts to manage demand at this stage will be most rewarded. At the interfaces between successive parts of the system important decisions are made about how the expressed demand might be best met.



Boundaries in the healthcare system where demand is generated and examples of tools used to manage that demand

Traditional reasons for increasing demand

- Cultural and behavioural (a much larger, informed and demanding middle class—consumerism, where the concept of rights is outpacing that of responsibility)
- Technological (specifically information technology and health technology)
- Epidemiological (long term care is now increasingly common relative to short term cure)

Ultimately, the best place to manage demand is before it meets the service—that is, through promoting self care. This needs more than simply exhortations not to use the service for minor complaints, but meaningful education and true empowerment of individuals, households, schools, and workplaces so we feel more competent and confident to meet simple health-care needs ourselves. This involves a bigger investment in advice lines, nurse practitioners, and self care manuals, and the continued enhancement of the roles of pharmacists and other health care professionals. NHS Direct, as proposed in the recent white paper on the NHS in England, has much to offer.⁴

Self care—In helping people make more appropriate decisions about their own health we must not compromise safety but instead explicitly share risk. This involves assessing the best content and format of information in self-care manuals that integrate consistently with the advice from health care professionals over the telephone or other forms of technology. There is much to be learnt from the experience of health maintenance organisations in America, many of whom issue comprehensive manuals and free phone numbers on enrolment. Importantly, a high degree of consistency exists between the advice in the manuals and from the professionals.

Primary care—In primary care general practitioners need to be supported to manage demand more extensively. Gatekeeping (more recently and appropriately called filtering) can be done much more successfully if primary care is supported with more knowledge sharing, more risk sharing, and a more graduated access from primary care to secondary care (or other statutory and voluntary services) (see boxes).

The power of knowledge

The knowledge that underpins primary care (and the way it is used) is essential in managing demand. This can be divided into the fears, understanding, and expectations of the patient; the evidence from valid, relevant, and accessible research knowledge; and an up to date knowledge about the facilities and support available from fellow healthcare professionals (especially in secondary care). Access to research knowledge has been undergoing most change recently and has the potential to help manage demand more rationally and consistently. Knowledge sources for both professionals and the public need to change from being there “just in case” to being there “just in time.”

Managing demand in secondary care and beyond needs another set of tools. Although fewer patients are seen than in primary care, many more resources are consumed. The ability to manage the pressure on the hospital’s front door is intimately related to the extent to

Example: of curtailing, coping, and creating demand

Demand	Heart disease
Curtail	Disseminate information on the most cost effective interventions for preventing, diagnosing, and treating coronary heart disease
Cope	Prioritise cases for ambulance and early treatment with explicit triage criteria Ensure thrombolysis for all suitable patients is given within target time
Create	Ensure through public education that people recognise: <ul style="list-style-type: none"> ● the symptoms of a heart attack ● the importance of early treatment

which the healthcare professionals in the hospital are prepared to support colleagues in primary care. This support involves decision support, explicit knowledge on generalisable research (on effectiveness and cost effectiveness) and localised knowledge on availability, access, pre-referral support, and outreach services. It is important to be able to be explicit about, and share the risk of, all decisions between the patient and the professionals (including the legal consequences⁹). For the general practitioner to refer and the physician to admit on increasingly smaller tolerances will cripple the system even more quickly. We need to be able to explain and share risk between doctor and patient, between primary and secondary care. This implies having senior people on the front door, not only to manage acute illness quickly, but also to see the patient at the front door, and sometimes refer home again, as a practice acceptable to both patient and general practitioner. "If in doubt, admit" may become an unaffordable policy.

Practical ways of meeting the same needs

Coping with demand is about exploring better ways of meeting the same need—that is, increasing the efficiency and convenience of the system without compromising quality (see boxes).

Creating demand may be an appropriate way of managing demand if there is a poor uptake of a preventive service—for example, breast screening—where early intervention would reduce the demand for alternative and less successful interventions later on. Examples of curtailing, coping and creating demand in heart disease are shown in the table.

Conclusion

We need to turn the consequence of the changing expectations in society into a fundamental part of the solution. We need to find the best ways of helping people make the most efficient and fair use of a service that will never have enough resources to do everything. Understanding of the ways of managing demand is in its infancy, though there is some evidence on their effectiveness. The remaining four articles in this series will explore the practical opportunities for demand management: before primary care, within primary care, between primary and secondary care, and within and beyond secondary care—in each case evaluating the available evidence.

With particular thanks to Philip Hadridge.

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More graduated access from self to primary care

11 pm: 10 year old with sudden high fever and rash

Choices for parent:

Traditional method
Ask family/friend

Developing methods

Ask family/friend
Consult self care manual
Phone national number
Phone local cooperative nurse practitioner
Phone local cooperative GP
Visit to nurse practitioner
Visit to GP
Visit from nurse practitioner
Visit from GP

Call GP to come and visit

More graduated access from primary to secondary care

7 pm Friday: 74 year old man (living with wife) had funny turn, gone off legs
Choices for visiting general practitioner from the local cooperative:

Traditional method

GP calls SHO on call
SHO: "Send him in..."
Ambulance arrives

Patient arrives at hospital
Patient admitted
Some weekend investigations
Monday morning ward round
More investigations

Developing methods

GP consults pocket decision support tool
GP phones hospital support service
Hospital support service advises "Watchful waiting" and shares the risk
Social services consulted by GP
Telephone message to GP
Midnight: paramedic drops in
Night sitting service arranged
Saturday morning visit from local nurse practitioner and social services
Quick visit to hospital and back
Own GP visits

Wife can't visit
Social support crumbles
Challenging discharge

Services can be offered...

In a different place	Intermediate or primary care <i>v</i> secondary care, in the community <i>v</i> in hospital
In a different way	Drugs <i>v</i> surgery, watchful waiting <i>v</i> immediate intervention, reactive <i>v</i> proactive telephone <i>v</i> face to face
By different people	Self care, nurse practitioners, or pharmacists or citizens <i>v</i> doctors
At a different time	Sunday morning <i>v</i> Monday morning or vice versa
With different levels of shared responsibility between professional and public	

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*Health needs assessment***Whose priorities? Listening to users and the public**

Joanne Jordan, Therese Dowswell, Stephen Harrison, Richard J Lilford, Maggie Mort

This is the fifth in a series of six articles describing approaches to and topics for health needs assessment, and how the results can be used effectively

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External inputs to health needs assessment and the prioritisation of health services may be seen as one means of addressing the “democratic deficit” in the NHS. Such external inputs can be discussed on three levels. The first concerns the formal governance arrangements of the service and encompasses questions about electing health authority members and transferring the NHS purchasing function to local government authorities^{1 2}; it is not discussed further here. The second level of input may be characterised by arrangements for consultation with the general public, whether or not they happen to be current patients or users. The third level concerns the consultation of current users about needs and priorities. The importance of these two levels was recently recognised in a new white paper.³

Consultation of the public

The nature and extent of public involvement in determining health needs has increased, but the quality of consultation remains questionable.^{4 5} Some health authorities have established ongoing consultation procedures, including citizens’ juries, large scale postal panels, and smaller face to face panels, but most consultation has consisted of one-off surveys of the public or consultation with local user groups. Most authorities have no provisions for ongoing means of consultation.⁴

These approaches may be classified according to two simple dimensions.¹ One dimension relates to whether respondents to the consultation exercise were provided with any information, and the second relates to whether respondents were able to engage in any discussion or deliberation in arriving at their views. These dimensions define the matrix shown in the box.

Citizens’ juries and similar panels of members of the public place respondents in the situation where they are

Summary points

Although health authorities have increased local consultation, its quality remains dubious, with greatest emphasis on one-off consultation exercises

Information gained through public consultation may either be marginalised or incorporated according to professional priorities

It is important to acknowledge limitations to professional knowledge as well as to respond to inequalities in health; through citizens’ juries, user consultation panels, focus groups, questionnaire surveys, and opinion surveys, local knowledge can be used to effect such a response

There is scope for greater local involvement in decision making

Changes to the organisation and funding of primary care are vital if effective involvement is to be sustained

informed about the issues and choices at stake and must deliberate with others to arrive at a recommendation.^{6 7} Such mechanisms attempt to collect the views of the public not necessarily as they are, but as they might be if information and the opportunity for discussion are available. Diametrically opposed is an approach that seeks to consult the public as it is, usually on the basis of statistically representative sampling. Such opinion surveys collect data from a generally uninformed public and do not encourage deliberation. The other two cells in the matrix are hybrids: focus groups encourage discussion of uninformed opinion, and in a few cases attempts have been made to provide a written briefing to survey respondents.

Either construction of the public—as uninformed and undeliberating, or as informed and deliberating—is open to objection, and of course any such objection can be used by NHS “insiders” as a pretext for ignoring or overriding the outcomes of consultation. The organisers of consultation exercises can help to produce the outcomes that they prefer by their choice of questions, though this can be avoided through involving the public in the formulation of the inquiry.

Some studies have found that participants on juries and panels have been satisfied with their experience and think that ordinary people can participate effectively in such exercises.⁸ Other research has found that respondents to opinion surveys are reluctant to accept a public role in determining priorities for health care.⁹ This suggests that mechanisms with informed and deliberated components may enhance participation when the aim is to produce substantive recommendations.



JANE SMITH

Responding to user groups

When health authorities have opted to involve existing user groups, it is because they have been influenced by legislative change and occasionally by strong personal commitment to user led services and have accepted the groups as legitimate stakeholders in healthcare decision making.¹⁰ Often, a strong feature of this recognition is officials' need for better information about existing services and about needs and priorities identified by the groups. When it is recognised that managers and professionals do not necessarily know best, user groups are seen as excellent conduits of information.

Even so, officials can be quick to qualify and circumscribe the influence of user groups, typically through questioning their "representativeness." This ambivalence is part of a more encompassing approach in which officials are able to undermine the legitimacy of groups, should the perceived need arise,¹ while at the same time using the user groups' views in their own negotiations with other officials.¹¹

Local consultation in primary care

Attention has been most keenly focused on the need and opportunity for local consultation within health authorities,¹² so it is no surprise that most initiatives have occurred at this level. Relatively little attention has been paid to local consultation specifically in primary care.¹³ The increasing role of primary care in purchasing, and most likely in future locality based commissioning of health services, makes it necessary to determine and respond to specifically local needs.^{12 14}

These developments set up the appropriateness of local health needs assessment as a basis of purchasing and commissioning, but they do not in themselves require local participation in such assessment. Many of the ways of assessing the health needs of a local population do not entail going anywhere near the population itself.¹⁵ The remainder of this section therefore discusses why primary care practitioners should involve the local community in decision making about healthcare provisioning, and importantly, considers the obstacles to such participation.

Two related issues bring into question the assumption that general practitioners are in a position to act as proxies for patients' health needs¹⁶: firstly, the evidence on differing perceptions of doctors and patients,^{17 18} and secondly, the disparity between demand and needs.^{19 20} Taken together, these highlight the danger of basing knowledge about the distribution of health (need) in a community solely on experience of general practice. Many health professionals, including general practitioners, see the proactive seeking out of need as secondary to a primary care responsibility for individual demand, and they see knowledge held by people living locally as "inferior" to that generated by clinical observation and diagnosis.^{21 22} Most illnesses, though, do not lead to a medical consultation,²³ so professional knowledge cannot be assumed to reflect the experience of individual patients, and presentation at surgery may best be understood as one expression of demand. One way of filling gaps in understanding is to consult the local community.

Methods of public consultation

- *Citizens' juries*—Participants are selected as representatives of public or local opinion. Juries sit for a specified length of time, during which they are presented with information to help in decision making. Typically, experts give evidence and jurors have an opportunity to ask questions or debate relevant issues.⁶
- *User consultation panels*—Consist of local people selected as representative of the locality or population. Typically, members are rotated to ensure that a broad range of views is heard. Topics for consideration are decided in advance and members are presented with relevant information to encourage informed discussion. Meetings are often facilitated by a moderator⁷
- *Focus groups*—Typically, semistructured discussion groups of 6-8 participants led by a moderator, with focus on specific topics. Debate and discussion are encouraged
- *Questionnaire surveys*—Can be postal or distributed (in the surgery, for example). This structured or systematic means of data collection allows information to be collected from a large sample of respondents and the relation between variables to be examined. Most appropriate when the issues relevant to the topic being investigated are already known in some detail
- *Opinion surveys of standing panels*—Standing panels are large, sociologically representative samples (typically 1000 or more) of a the population in a health authority; they are surveyed at intervals on matters of concern to the authority. There is usually a replacement policy aimed at ensuring that individuals do not serve on the panel indefinitely

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Providing for equity

The issue of equity in health (provision) also makes it incumbent to move beyond a model of primary care that is based on professional response to demand—to a model that recognises the importance of responding to need that is otherwise unidentified. There is increasing evidence that the distribution and degree of inequality in economic welfare has a direct impact on health.²⁴ Local participation in healthcare decision making can run the danger of increasing this inequality by allowing the members of the public who are most able to register their demands or needs to do so at the expense of the less articulate²⁵; nevertheless, if participation is handled appropriately, previously marginalised groups can be provided with a voice and can be involved in decision making.²⁶

Approaches to public consultation on health care priorities

	Informed	Uninformed
Deliberated	Citizens' juries User consultation panels	Focus groups
Undeliberated	Questionnaire surveys with written information	Opinion surveys of standing panels / one-off questionnaires

Current potential for consultation in primary care

What scope exists for local consultation under current healthcare policy and organisation? As already mentioned, problems arise from the fact that not only is primary health care essentially demand driven but this demand is arbitrarily divided into practice specific populations which often do not correspond to naturally occurring geographical localities and populations.¹³ Professional and official thinking therefore needs to acknowledge in both the organisation and funding of primary care the appropriateness of responding to the needs of the local (as distinct from the practice) population.²⁷

The poor understanding and limited uptake of local consultation within primary care²¹⁻²⁸ arises partly from the absence of relevant training—which makes an inherently challenging activity even more difficult. Working with groups representing different community interests demands considerable skills and flexibility, and health professionals are currently poorly prepared for this.²⁶ Local people may not be used to having their opinions invited, let alone being asked to take a more active role.²⁹ One-off consultation initiatives are thus likely to have limited benefit, and they may work against longer term effectiveness, which depends on proper structures and mechanisms for sustained, meaningful communication and action.

There is already considerable scope for community based health needs assessment within primary care. Members of the wider primary healthcare team are already in touch with local networks, including resident's associations, mother and toddler groups, schools, and other voluntary organisations.³⁰ Community nurses have been producing community profiles, which could be used to develop stronger links with the community.¹³ The spread of appropriate knowledge and skills and the practical need to divide any workload makes it vital to involve the whole primary care team, and such involvement is in line with the underlying general ethos of full participation in healthcare decision making.³¹

Reconciling conflicting needs

One overriding issue remains. Comprehensive health needs assessment is likely to produce different, potentially conflicting needs.¹⁵⁻³² How are these different priorities, views, and opinions to be weighed against one another in order to avoid a position of stalemate and to effect positive change? Available suggestions may differ, but academic contributors and decision makers alike are acutely aware of resource limitations and their implications for meeting the full range of need identified through any health needs assessment process.³²⁻³³ There are no easy answers, but with regard to local involvement at least it is clear that people must be involved in identifying need and also in prioritising and responding to these needs.²⁶

There is no doubt that the concept and practice of local participation in health needs assessment is particularly challenging. Although there are no models for how to go about it and there are a number of potential obstacles, there is already considerable potential for existing arrangements to be extended to incorporate local participation. While it has been argued²⁴ that the recent

policy obsession with needs assessment has been prompted by a desire to reduce public expenditure, this should not detract from the possibility of using needs assessment, particularly that with community involvement, as a means of not only promoting good health but reducing inequalities in its distribution.

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