Consulting the public about health service priorities

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Consulting the public is an important component of commissioning health services. Somerset Health Authority has devised a method of consultation using eight focus groups meeting three times a year. Each group consists of 12 people, and together the groups are demographically representative of Somerset's population. The groups are asked about issues that are concerning the health authority, and their views have influenced health authority decisions. Each group is given some background information before the meeting, together with more information at the meeting. The discussions are tape recorded and analysed for qualitative information, but the groups are also asked to score certain priorities. The groups have been found to be representative, valid, and focused on community rather than individual values. Health authorities wanting to know the values people attach to health services should adopt this qualitative approach to consultation.

Few health authorities know what values their public holds about health priorities. Under the impetus of the Oregon exercise (in which the public helped to decide what services would be provided with public funds[1]) and with express government encouragement[2] a number of authorities have sought the views of their populations on various topics.[3,4] Often such consultation has used the public as consumers to comment on how specific services should be changed. When it has focused on broader issues the questions have tended to be hypothetical and the results difficult to interpret.[5]

Yet investment decisions about health service priorities are being made by health authorities without knowledge of what the people for whom they are making these decisions are thinking. While some decisions can be made on technical grounds or derive from government directives, others are based on value judgments. It is these that Somerset Health Authority has sought to elicit from its public. A research project was set up to establish an appropriate method of community consultation with the long term aim of building a consensus on the values to be used to guide health resource allocation. The challenge was to devise a method that was representative, valid (and seen to be so), restricted to broad values, and focused on community rather than individual values.

The method adopted using local panels

Eight health panels have been set up across Somerset health district. These are each composed of 12 local people, representing as far as possible a cross section of the population, with men and women of all ages and backgrounds. Selection is arranged by professional recruiters using a quota sampling technique to ensure a spread of characteristics. To ensure a regular supply of new voices each person has a one year term, with a rolling membership so that four new people are brought on to each panel (and four retire) at each meeting. So that no one is excluded for practical reasons panel members are paid £10 for each meeting attended to cover any expenses, and transport is provided for those without cars.

The health panels have met five times over 18 months, the last round being too recent to be included in this analysis. The topics for each meeting are proposed by the health authority in consultation with the research team. They are "live" issues of genuine concern to the authority, rather than hypothetical issues. The topics are listed in table I. As discussions cannot be undertaken sensibly when people are inadequately informed some information is provided to panel members. Based on initial background information on each topic supplied to the health authority, the research team prepares two sets of information for panel members: a short paragraph sent ahead of the meetings, which members are encouraged to discuss with family and friends, and a fuller discussion for use in the meetings. This covers the nature of the problem or treatment, the number of people affected, costs of provision, and any controversial issues surrounding the topic (see example in box 1).

Box 1—Patient choice

Information provided to panel members during meeting

- Not everyone wants to be treated locally, even though the health authority is already paying for local treatments
- It is the current policy of the health authority to pay for hospital treatment wherever the patient wishes, even if it involves extra costs
- Patients must discuss this with their GP and sometimes they agree to local treatment, when the extra costs are pointed out
- The reasons for wanting treatment elsewhere (aside from when it is unavailable locally) include:
  - continuity of treatment to people recently moved to the area (extra cost last year= £23 000)
  - continuity of treatment for arrangements set up some time ago—for example, long term renal care (extra cost last year= £267 000)
  - patient preference, for example to be near relatives (extra cost last year=£8000)

Questions to panels

Should the health authority stop paying for treatment outside Somerset for any of the above reasons?
Should there be an upper limit on the total amount spent for this purpose?
If so, what should this limit be?
£10 000
£50 000
£100 000
£500 000

Answer from panels

Treatment of patients outside the county should be strictly limited. Continuity for new residents was supported by over half (57%), but only a minority supported other grounds (continuity for others: 43%; patient preference: 31%). The principal concern here was not to waste local NHS resources.

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BMJ 1995;311:1155-8

The meetings are facilitated by an expert in group dynamics. All discussions are tape recorded and transcribed verbatim. The principal rationale of our approach to consultation is that those involved should have the opportunity to explore issues in some depth.[6] Most people need a period of listening to the views of others and talking about issues themselves to clarify their own thoughts on any complex question. In the absence of such discussion many people simply do not know what they think. An additional benefit of this approach, however, is that considerable information can be gained on panel members' thinking and values by careful analysis of the transcript.

The views collected from the exercise are of two kinds. Besides the qualitative material, a system of "decision sheets," by which panel members vote anonymously on the topics under discussion, provides some quantitative data. For some issues this is a matter of a yes or no answer to a specific question; in others, it entails listing a series of items in order of priority.

A seminar was set up to tell local doctors about the consultation project and explore their responses to it. A random sample of general practitioners and hospital consultants were invited to take part. Of 80 invited, 38 attended, including 26 general practitioners (of whom four were fundholders) and 12 hospital consultants. The research team presented the nature of the arrangements and information on the characteristics of the participants in some detail. As a means of gauging doctors' confidence in the results arising from public consultation, they were asked to complete decision sheets at the end of the seminar.

The results of the panels in action

On average 10 people attended each panel meeting. The characteristics of those who attended the meetings were similar to those of the population of the county (see table II). The only significant difference was a slight over-representation of those with experience of the health service.

The best questions were found to be about live issues due to be debated by the authority itself. They were taken from strategic plans, policy documents, or purchasing programmes. For instance, the panels were asked about clinically unnecessary antenatal visits when a maternity strategy was being considered. A question about out of county referrals was asked when the extracontractual referral policy was being revised. In each purchasing programme there are some borderline proposals of more or less equal importance to health professionals. It is these that were chosen for priority setting by the panels. Other examples, together with summaries of the panels' answers, are given in boxes 1-3.

The results are collated and reported to the authority after each round of meetings. Consistency between panels was shown in orders of priority, with agreement between panels for all questions. A clear consensus within panels was reached in over three quarters of the

TABLE I—*Questions asked of each panel at five sets of meetings*

1	Local health issues raised by the panels	Waiting lists; should there be priority for the elderly?	Prioritise the following: • Paediatric nurse specialist • Cancer nurse • Additional cataract operations • Clinical genetics • Additional chiropody • Improved drug service	
2	Should coronary bypass operations be denied to all smokers altogether? Should coronary bypass operations be denied to smokers who refuse to give up smoking? Should *second* coronary bypass operations be denied to smokers who have refused to give up smoking? Should smokers have low priority for coronary bypass operations, compared to other people?	Should the health authority pay for all sports injuries? If no, should some limit be set? Should people who undertake certain sports be required to have special insurance?	Should the provision of health visitors be concentrated in areas of greatest need even if this means that some women receive fewer routine visits?	Should the health authority pay for treatment outside Somerset for any of the following reasons? Continuity of care for people recently moved to the area? Continuity of care for longstanding arrangements? Patient preference? Should there be an upper limit on the *total* amount spent for this purpose? If so, what should this upper limit be: £10 000, £50 000, £100 000, £500 000?
3	Should more night medical centres be set up, to save on GPs' visiting time and costs? Would you mind if your GP was not available during the day because he or she had worked through the night?	Should a fee be charged for the hospital car service to those who are medically fit to travel? If yes, should they pay the full cost or a flat fee of £2 per journey? Should the car service be extended to people visiting relatives in hospital? If yes, should they pay the full cost, a flat fee of £2 per journey, or no fee at all?	Please indicate an order of priority for the following treatments, by numbering 1, most important to 4, least important? • Intensive care of extremely low birthweight babies • Orthodontics solely for appearance • Cochlear implants • Complementary medicine	
4	Prioritisation of: • Psychiatrist for severely mentally ill people in the community • Additional chiropody • Drop in centre for people with dementia • Stroke team • Physiotherapy for people with learning disabilities • Publicity for cervical screening and closer quality control	Should people with terminal cancer and less than six months to live be given intensive treatment or simply kept free of pain and suffering?	How might the system of public consultation be improved?	
5	Should doctors be urged to establish more clinics run by nurses to advise patients with an ongoing condition? Would you be willing to see a practice nurse, rather than your GP, for an ongoing condition? Should doctors be urged to use nurses as the first source of advice on diagnosis or treatment for new patients? Would you be willing to see a practice nurse, rather than your GP, for a new condition?	Should the health authority pay for more antenatal visits than medically required (where there are no complications), if women want them?	Should the waiting times for general surgery be: Ten months? Eight months? Six months?	

issues which required a yes or no answer; consensus was defined to mean that two thirds of the individuals in a panel agreed one way or the other.

The medical seminar was used to help assess whether the process was seen to be valid. A higher proportion of doctors felt they would have confidence in the results than those who would not (24% compared with 10%), but most doctors (66%) remained fairly sceptical.

TABLE II—*Comparison of achieved sample and Somerset population. Results are percentages*

	Round 1 (n=79) %	Round 4 (n=68) %	Somerset county %
Sex:			
Male	41	46	48
Female	59	54	52
Age:			
17-25	14	19	15
26-40	30	21	24
41-60	27	37	31
⩾61	29	24	31
Housing:			
Rented (local authority)	20	15	17
Rented (other)	4	6	17
Owned	73	75	73
Other	1	4	
Not recorded	1		
Occupation:			
Paid work	46	51	55
Unemployed	8	3	4
Something else	47	46	41
Children under 15:			
Yes	34	34	27
No	66	54	73
Not recorded		12	
Car:			
0	15	15	22
1	56	49	48
2	29	37	30
Been to hospital in past year:			
Yes	46	40	26
No	53	60	74
Not recorded	1		

Box 2—Smokers and coronary artery bypass surgery

Questions to panels

Should coronary bypass operations be denied to all smokers altogether?

Should coronary bypass operations be denied to smokers who refuse to give up smoking?

Should *second* coronary bypass operations be denied to smokers who have refused to give up smoking?

Should smokers have low priority for coronary bypass operations, compared to other people?

Answer from panels

Smokers should not be denied bypass operations (99%). But if they are unwilling to stop smoking, a second operation should be denied (51%) and, according to some (25%), the first. Only a minority (28%) felt that smokers should have lower priority for such operations.

There was strong commitment to a universal health service based on

- the view that all life is valuable
- the view that people have a right to the NHS as they have paid into the system
- compassion

Self inflicted harm should not be a principle for deciding care, and there was a fear that smoking would be the thin end of the wedge to the rule of universality. A different policy for continuing smokers was argued on the basis of the lower prognosis, the need for people to take some responsibility for themselves, and cost.

Box 3—Practice nurses

Questions to panels

Should doctors be urged to establish more clinics run by nurses to advise patients with an ongoing condition?

Would you be willing to see a practice nurse, rather than your GP, for an ongoing condition?
Should doctors be urged to use nurses as the first source of advice on diagnosis or treatment for new patients?

Would you be willing to see a practice nurse, rather than your GP, for a new condition?

Answer from panels

Virtually all members (98%) favoured the establishment of more clinics using practice nurses for chronic conditions and indicated they would be happy to attend them most of the time (78%) or occasionally (19%). In contrast, fewer than one third (29%) thought that practice nurses should be used to screen patients.

Although panel members supported an increase in the use of practice nurses, both to save doctors' time and to avoid patients waiting for long periods, there was a strong concern that doctors should be responsible for diagnosis, except in the case of very minor conditions. If nurses were to be used more extensively, however, it would be important to offer choice to patients

Discussion

OBTAINING PUBLIC OPINION

Our use of a focus group approach was based on an assumption that people need an opportunity to explore the arguments in order to clarify their views on new and complex issues. This group approach also enables people to focus more easily on common—rather than individual—benefits. When faced with an individual interviewer, people are more likely to consider their own personal interest on an issue. It is clear from the discussions that panel members made the conceptual leap to the common concern.

The system established did work to develop a consensus on broad values, focused on community benefits. Over time, approaching some value issues in different ways (for instance, different kinds of self inflicted illnesses) will help to build up a broad picture of the ways in which members of the public respond (see, for example, the selection of quotations in box 5).

THE CONSULTATION PROCESS

The panel meetings have generally been well attended. Panel members were very positive about the information provided and welcomed the decision to provide this before meetings as well as during them. Many panel members did discuss issues with family and friends.

The decision sheets, providing a poll of considered opinions after the discussion, serve as a useful counterweight to the qualitative information elicited. No one objected to completing these. When people might be shy of voicing minority views in public they could give their final vote privately.

The fact that people learn what they think while discussing the questions was well stated by one panel

Quotes from panel discussion

"I'm completely opposed to smoking, but I'm opposed to moral judgments being made on people because they are sick.... If we're offering a health service, we've got to offer it to everybody regardless of how they behave."

"The NHS is a service. It's not a charitable organisation.... It's paid for by everybody, irrespective of lifestyle... you can't exempt great chunks of the population."

"If you start with cardiac surgery and smokers, is it going to lead on to not treating people with lung cancer and then people with obesity who eat a high fat diet...."

"What about a drink-driver, who is in a crash... are you going to say you can't go into a hospital for surgery? Where do they draw the line?"

"If there's a limit to money, you've got to go for the people who've got the best chance."

"How can we waste money on someone that's not even prepared to help themselves when there are other people urgently in need of operations?"

member: "It makes us all discuss.... You see the questions and you think, "Ah, yes, I think so and so." And then when you come to talk and hear other people talking about it, you really get into it in depth and you change your mind, juggle it around a bit. It's much better than if you were to stop and ask someone in the street, 'What do you think?'"

ARE THE FINDINGS VALID?

Although broadly representative of the population of Somerset as a whole, the sample sizes are small—as with all qualitative research—and it is necessary to rely on a process of "logical" rather than statistical inference to build confidence in the generalisability of the findings. The breadth of arguments used by the panels in reaching their decisions and the consistency across panels in terms of both the issues raised around individual topics and the tendency to vote in similar ways provide that confidence.

Because biased recruitment and selective participation have been major problems in consultation exercises elsewhere,[1-5] every effort has been made to encourage participation by all eligible members of the population contacted—not only those who have a particular interest in doing so. This applies both to recruitment of respondents and to their participation in discussion.

The use of trained and experienced group facilitators, competent in managing group dynamics, is essential both to ensure maximum participation by all panel members and full exploration of deeply held values by means of carefully applied non-directional probing.[7] Each issue is tackled in the same way: the information is read through and the options outlined. The panels are then encouraged to discuss not only their detailed responses but the beliefs and values underpinning them.

We undoubtedly hold a richer bank of information than could be obtained through a more conventional structured survey. Our tape recordings are of lively discussions in which complex issues are discussed at length and values clarified. It is clear too that individuals—by and large—conscientiously debate community rather than individual perspectives. These recordings are then analysed with due rigour. Because of these arguments, we would question the validity of any findings arising from a more quantitative approach to consultation on these issues.

One measure of validity is the extent to which outsiders believe that the system established is valid. The medical seminar was set up in part to test local doctors' responses to the process. The problem here is how to assess its results. In all, more doctors felt they would have confidence in the results than those who would not, but most doctors remained fairly sceptical. These results, though not statistically significant, were more positive than expected. We had assumed that doctors would be both sceptical of purchasing decisions being based on non-medical opinion and resistant to a qualitative approach to eliciting information.

HELPING TO MAKE HEALTH SERVICE INVESTMENT DECISIONS

Somerset, like other health authorities, relies on advice from a variety of sources in determining investment decisions. What has been absent until now is knowledge about how local people value different services. A key to the success of the panels has been to choose questions requiring value judgments and not technical knowledge and to leave the technical questions to the professionals.

With experience over two years the authority has gained confidence in the validity of the results of the panel discussions. This has allowed more weight to be attached to the findings. For instance, the panels' top two priorities among six borderline developments have been included in the purchasing programme this year. The cardiac surgeons are being asked to limit second coronary artery bypass grafts to non-smokers, subject to suitable advice at the time of the first operation. An out of hours general practitioner scheme is under way.

In conclusion, the methods adopted have been found to work. Each health authority will want to obtain the views of its public about these important issues. Here is one approach that can be used to help them in this task.

We thank Robin Legard, Ann England, and Rupert Williamson for facilitation of the panels; Richard Pollard for statistical advice; the steering group for their help and advice; and panel members for their enthusiastic involvement in the project.

Copies of the reports of each round of panel meetings are available on request.

Source of funding: Somerset Health Authority.

Conflict of interest: None.

1 Kitzhaber JA. Prioritising health services in an era of limits: the Oregon experience. *BMJ* 1993;307:373-7.
2 NHS Management Executive. *Local voices. The views of local people in purchasing for health.* London: Department of Health, 1992.
3 Ham C. Priority setting in the NHS: reports from six districts. *BMJ* 1993;307:435-8.
4 Murray SA, Tapson J, Turnball L, McCallum J, Little A. Listening to local voices; adapting rapid appraisal to assess health and social needs in general practice. *BMJ* 1994;308:698-700.
5 Pollack AM. Local voices: the bankruptcy of the democratic process. *BMJ* 1992;305:535-6.
6 Patton MQ. *Utilisation focused evaluation.* Beverley Hills, CA, USA: Sage, 1986.
7 Mostyn B. *Handbook of motivational and attitude research techniques.* Bradford: MCB Publications, 1978.

(Accepted 27 September 1995)