

Researching Health Needs



JUDY PAYNE

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A Community-based Approach

Judy Payne



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PREFACE

The idea of writing a user-friendly book about how to do health and social research has its origins in work I did for the Healthy Plymouth Alliance. The Alliance needed a short handbook on the techniques used in health needs assessment of local communities. It was designed as a practical guide that could be used both by professionals and directly by local community groups. While preparing the handbook, it became clear that there was a need for a more detailed and extensive text. Although this would still be user-friendly and practical in style, it could also be used by students on undergraduate and post-qualification courses in health, community work, social care and social science, and by practising professionals.

The result is this book, which sets out ways of doing social research into community-based health issues. In one sense, it is a book about *social* research, in which the examples and the development of the ideas are taken largely from community health. Viewed in this way, it should be helpful for anyone learning about social research: the methods described are equally used in sociology and social policy. In another sense, it is a book about *health*, and ways of thinking about it and investigating it. Based in a framework of local people and processes, it seeks to avoid a 'medical model' of health and illness, and to take account of the complexity of human life, agencies and policies.

It covers all the main methods that have been used to research health in local communities, beginning with the more straightforward and practical steps. I have tried to start with common sense issues, and to show how these are often a little more complicated than they seem. In the same way, doing research often entails specific procedures (and harder work!) than might appear to be the case at first sight. The aim throughout is to give enough information to enable research to be done, without going overboard on the technicalities.

Because the book tries to avoid being too technical, it also indicates the points in doing research when more specialist help should be obtained. Thirty years of doing research and teaching social research methods (much of it in a health setting) have shown me that we cannot all be equally expert in everything. Doing good health research, and doing it confidently, entails recognizing what we can do, and when we need to call on the skills of other professionals.

The result is a pragmatic book, dealing with the practicalities of how

to do research, from first thoughts through to writing it up, getting the message out, and trying to influence health and social policies. What I have drawn together are methods from a range of perspectives. Some of these are conventionally called 'qualitative', while others are 'quantitative'. In practice, the boundary between them is less clear-cut than most texts imply. Underlying research is a way of thinking through questions systematically, and then choosing the appropriate techniques to carry it out.

It follows that the book has a core approach that is developed and worked through in each chapter. Each chapter starts with an overview, describes a number of methods, both in terms of practical steps and their advantages and disadvantages, and concludes with a practice exercise and a reminder of key concepts and terms. Examples of recent studies are included, so that the principles can be seen in concrete form. Details of case studies, a glossary and sources are included at the end of the book. Many of the chapters can be taken as free-standing, so that readers will be able to follow their own order or selection of methods through most of the book. It certainly has not been constructed to be read from cover to cover in one sitting, and some of the more detailed sections will repay re-reading.

Although I might have eventually got round to writing this book, it was my work for the Healthy Plymouth Alliance that led me to doing it now. The HPA Board members gave me every encouragement during the preparation of the original handbook. In particular, Maggie Grant, the Co-ordinator of HPA was always supportive and enthusiastic. During the writing, I have been fortunate that my partner, Geoff Payne, is also a Professor of Sociology and health researcher at the University of Plymouth, and my sister, Dr Jennifer Roberts, a Reader in the Department of Public Health and Policy at the London School of Hygiene and Tropical Medicine. They contributed a very welcome resource of personal and professional support. I would also like to acknowledge past and present colleagues and students in Newcastle, Aberdeen and Plymouth, in whose company I have developed my own understanding of the processes of social research. Finally, I am grateful to Karen Phillips and Kiren Shoman for their advice during the preparation of this book for Sage.

CHAPTER I

INTRODUCTION

Despite the many changes to the NHS in the 1990s, successive governments have drawn on two underlying principles in planning and resource allocation. First, allocation strategies and practice should be based on the best available information and evidence. Second, health authorities should consult and inform their local populations about needs and priorities. Thus, Mawhinney's statement that 'decisions must be based on sound evidence about health needs' (1993: 18) was echoed four years later by Jay when announcing the publication of the Department of Health's *Policy Research Programme*:

it [is] vital that government policy [is] based on thorough investigation and proven evidence . . . Research and development plays a crucial role in providing information on a wide range of issues that will enable us to improve the quality of services on which the health and well-being of the whole population depends. (Department of Health, 1997c)

Similarly, the importance of local consultation put forward in *Local Voices* (NHS Management Executive, 1992) is repeated in the 1997 White Paper 'Health Authorities will need to: involve the public in developing the Health Improvement Programme' (Department of Health, 1997a: para 4.19). The Health Action Zones announced in this White Paper are partnerships of local statutory authorities, voluntary organizations and local people working together to develop 'innovative strategies' to improve health in their area.

The two underlying principles of evidence-based planning and practice, and local consultation and involvement are brought together most clearly in the requirement that health authorities undertake *health needs assessments* of their local populations. This was made a statutory duty in the 1990 NHS and Community Care Act, and reinforced in the 1997 White Paper. The first 'key task' of health authorities is '**assessing the health needs** of the local population, drawing on the knowledge of other organisations' (Department of Health, 1997a: para 4.3). However, although the National Health Service Management Executive (NHSME) recommended a possible approach to carrying out these assessments (NHS Management Executive, 1991), a wide variety of techniques and methods have been used. These range from the calculation of mortality and morbidity rates for different diseases (an *epidemiological* approach), through QALYs – quality-adjusted life year

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estimates (an *economics* approach), to social surveys, focus groups, forums and less formal discussions and observations in local communities (a *sociological* approach).

This book provides a description of the main methods used in *sociological approaches* to community needs assessments and community health profiling. All of the methods discussed here are ‘tried and tested’. They have been employed by sociologists and others for many years – some for more than half a century. Often they have been used in combination – a *mixed-method* or *triangulation* approach – to get information about different aspects of a topic or to validate the results of other methods.

Selecting which methods to use is largely determined by the nature of the research question (what you want to find out) and the available resources. In addition, it will depend on the particular theoretical perspective and goals of the researcher. In finding out about the health needs of local populations, this will involve what definitions of ‘community’, ‘health’ and ‘need’ are used, and why the research is being undertaken.

This first chapter provides a framework for the detailed discussions of these methods in later chapters. As we shall see, these apparently familiar and straightforward words hide a complex set of conflicting meanings once we begin to unpack them. First, we will look at the different meanings of the terms ‘community’, ‘health’ and ‘need’. This is followed by a discussion of the research process and the different research strategies – what ‘doing research’ involves. Again, we will discover that what at first sight seems common sense and easy, actually is a technical and sometimes challenging set of activities.

What do we mean by ‘community’, ‘health’ and ‘needs’?

Health needs assessments of communities are descriptions of the ‘health states’ and ‘needs’ of the people belonging to those communities. Within the NHS, they are currently defined as

The process by which a Health Authority *uses* information to judge the health of its population and then determine what services should be provided locally. (NHS Executive, 1998: 121; emphasis added)

This is an extremely exclusive definition in that it refers to ‘use’ rather than information collection. Further, it restricts the process to activities carried out within the NHS, and health authorities in particular. However, many community groups and local health alliances (for example, many *Healthy Cities* projects) have undertaken health

assessments and health profiles of their communities. This information has first been collected using many of the methods discussed in the following chapters and then *used* as part of the assessment process. The definition offered by the National Health Service Executive (NHSE, the successor to the NHSME) also carries the implication that only health authorities can determine what services are provided, but we can all have our own views on this. Moreover, by avoiding any definitions of 'health' and 'needs', the NHSE carefully sidesteps what Foreman (1996) has termed 'complex and contestable' conceptual issues. In addition, it defines the appropriate population group as that covered by each local health authority. In contrast, many health needs assessments have covered different community groupings.

Community

In everyday usage, **community** is often used to refer to the population of a geographically defined location. In contrast to **locality** which refers to the geographical area, *community* emphasizes the social dimensions that result from living in a particular location, especially the shared values, aims and actions of a population group. However, the term is often used to refer not just to the resident population but also to those who take part in or have an impact on its social life: those who work there, for example, but live elsewhere.

Again, communities may be made up of groups of people who come together for a certain purpose: for example, a school, a work group or a hospital – *institution-based* communities. Further, *community* need not necessarily be restricted to a particular locality or site. Groups of people who share some common interest or characteristic may be regarded as *communities of interest*: for example, the Anglican community, the Black community, mother and baby groups, Manchester United supporters.

Although these concepts of *community* convey ideas of social cohesion, cooperation and solidarity, this is not always the case. It is likely that any one community will be composed of members of other communities. For example, a locality-based community will consist of people who belong to different work-based communities, ethnic communities, religious communities, political communities etc. Such *overlapping communities* are therefore likely to experience a range of disagreements and conflicts amongst their members.

An important aspect of the concept of *community* is that of a group of *people recognizing that they have something in common*. Unless they do, they can only be regarded as a 'potential' community: a group of people who are seen from the outside as a community but who do not themselves feel that they share a common identity or have a need to

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cooperate. Community development is the process by which this identity and cooperation is encouraged.

Any studies that focus on communities will have to take account of these various dimensions in determining the most appropriate approach(es) to be adopted.

Health

We use the word *health* in many ordinary conversations: about people – ‘what a *healthy*-looking baby’; about ideas and things – ‘that’s a *healthy* attitude to take’; and about the environment – ‘it’s a very *healthy* place to live’. In all of these examples *health* is used to mean a positive characteristic or state: good as opposed to bad. On the other hand, in the medical context, *health* is defined negatively in terms of the absence of disease, impairment, disability or handicap. This approach is illustrated by the way in which the health of the population is assessed by comparing death rates and disease occurrences over time and between groups (*epidemiology*). For example, an examination of data used to monitor government targets and those included in public health reports shows that many of the main indicators of *health* are *death rates* and *illness rates*.

This very narrow medical definition of health is gradually being replaced by a more positive and broad concept: *health as well being*. As early as 1948, the World Health Organization (WHO) included in its constitution the statement that ‘Health is a state of complete physical, social and mental well being’. Here, health is seen not just as the absence of disease but is also associated with the *quality of life*. Thus the 1997 White Paper recognized this distinction in setting out a new vision of ‘an NHS that does not just treat people when they are ill but works with others to improve health and health inequalities’ (Department of Health, 1997a: para 1.1). This wider (*holistic*) definition includes the social, economic and environmental circumstances that affect people’s ability to experience a healthy life. The influence of such factors as unemployment, occupation and residence on death and illness rates has been acknowledged since Victorian times within the public health movement, and the reduction/eradication of such inequalities was the guiding principle behind the introduction of the Welfare State in the 1940s. However, research carried out since the late 1970s shows that these inequalities still exist and are, if anything, increasing (see, for instance, Department of Health, 1998b).

The present Labour government has placed the reduction of these inequalities at the centre of its health policy. The 1998 Public Health Green Paper identified the many ‘complex causes’ of these inequalities

some are *fixed* – ageing, for instance, or genetic factors [Others can be changed.] These include a range of factors to do with how we all live our lives – diet, physical activity, sexual behaviour, smoking, alcohol, and drugs [*lifestyle*]. *Social and economic* issues play a part too – poverty, unemployment and social exclusion. So too does our *environment* – air and water quality, and housing. And so does access to *good services*, like education, transport, social services and the NHS itself. (Department of Health, 1998a: 5; emphasis added)

There is a recognition here that health is not just a *medical* matter. Because of these differing views of what constitutes ‘health’, it is important to construct a working definition that states clearly what factors you mean to include before undertaking an investigation of health needs.

Needs

There is even less agreement about the definition of *need* than there is about *community* or *health*. Much of the literature on health need draws on a definition put forward more than twenty-five years ago that distinguished four types of need: *normative* (as defined by professionals/experts); *felt* (wants, wishes, desires); *expressed* (felt need turned into action or vocalized: for example, asking for pain relief, striking for more pay); and *comparative need* (inequalities) (Bradshaw, 1972).

These distinctions, although of value for clarification purposes, are of limited use when investigating the health needs of communities. Clearly, people’s perceived health needs (felt needs) are influenced both by ‘expert’ definitions and by comparisons with the health states of other individuals and groups. Thus *need* may be defined in terms of comparative standards or inequalities. This is highlighted by the stress on inequalities in the Public Health Green Paper (Department of Health, 1998a).

An alternative approach is offered by Doyal and Gough in their book *A Theory of Human Need* (1991). The authors have developed a theory of universal human needs based on the basic requirements of physical health and personal independence (*autonomy*). These are achieved by satisfying what they term *intermediate needs*:

- adequate nutritional food and clean water
- adequate protective housing
- a non-hazardous work environment
- a non-hazardous physical environment
- appropriate health care
- security in childhood

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- significant primary relationships (with family, friends, neighbours)
- physical security
- economic security
- appropriate education
- safe birth control and child-bearing.

The more detailed definitions of these intermediate needs are then determined at the national/local level. The main problem with the use of this theory in a needs assessment exercise is that of defining what is meant by 'adequate', 'appropriate', 'non-hazardous', 'significant' and 'safe'. These terms would have to be further clarified before any research based on this theory was undertaken. An example of the use of this theory of need can be found in a study of local needs carried out in Leeds in the early 1990s (Percy-Smith and Sanderson, 1992).

A further aspect of need concerns that of *satisfying* or meeting needs. This naturally concerns decisions about resource allocation and the setting of priorities that are basically political and ethical in nature (for example, should deprived areas have more money allocated to them than other areas?; should the treatment of certain illnesses have a higher priority than others?). Thus *need* has been defined for community care assessment purposes as 'the ability of an individual or collection of individuals *to benefit from care*' (Department of Health, 1993: 6; emphasis added). This contrasts with the statement in the 1997 White Paper where

access to [the NHS] will be **based on need** and need alone – not on your ability to pay, or on who your GP happens to be or where you live. (Department of Health, 1997a: para 1.5)

Here *need* is not overtly defined. Later in the same chapter, there is the suggestion that it refers to felt or expressed need: 'responsive to the needs and preferences of the people who use [the services of the NHS]' (para 1.19). However, the same document also makes reference to decisions being 'best made by those who treat patients [but] set [in] a framework . . . to ensure consistency and fairness' (para 1.22).

Doing research

Doing research about a community or social group is, in many ways, an extension of what we do in our everyday lives. If we want to find out about something, we ask our friends what they think, we watch television or read newspapers and magazine articles. We then evaluate all of this information, selecting the most important and useful to us, in order to reach conclusions as a basis for some further action. The main