Patients' views of priority setting in health care: an interview survey in one practice

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Abstract

Objectives—To explore the assumptions underlying consumers' responses to questions of resource priorities in the NHS.

Design—Qualitative analysis of semi-structured interviews with a heterogeneous sample of 16 patients drawn from a general practice.

Results—Interviewees were not persuaded that they had a legitimate role to play in the prioritisation of services. They supported the principle of equity and were reluctant to use their own personal needs as a basis for resource allocation; instead they argued from what they perceived to be the needs of others.

Conclusions—Paradoxically, surveys of consumers' views on health care priorities probably do not elicit the personal ideas of respondents but tap into a more general ideological position closer to an earlier collectivist notion of health care.

Introduction

Determining how health care resources should be allocated—often termed rationing or priority setting—has traditionally been carried out by health care personnel, usually doctors but increasingly managers. Because priority setting entails assigning value to different outcomes, however, the consumers of health care have a legitimate claim to be involved in the process of allocating resources.¹

Mechanisms for involving local people in purchasing decisions are still evolving. The commonest approach has been to use surveys in which questionnaires invite respondents to choose between listed services.^{2,3} Questionnaires assume, however, that the meaning of any question is the same for everyone, researchers and researched alike, yet there is no evidence that the general public shares a community of meaning about priority setting, never mind differences in views about specific services. Indeed, Bowling and her colleagues recognised these limitations of questionnaire surveys and suggested that the only valid way of hearing the voice of the public may be by one to one interviews.³

Developing some understanding about how the public approaches the problem of determining priorities is therefore important. Accordingly, semi-structured interviews were held with a small sample of the patients of one inner city general practice. The interviews focused on the source and content of the information that helps shape the thoughts, beliefs and values that in their turn help to determine individuals' opinions about the priorities within health services.

Methods

The study was carried out in a two handed inner city practice. The practice list covers an ethnically mixed population, about a quarter of whom attract Jarman

deprivation allowances. The practice has an annual patient turnover of 30%, the stable 70% tending to be long term Pimlico residents, often with several generations of family locally. A sample of 20 patients were invited to take part in a semistructured interview about their views on how health services should be determined. The sample was chosen to reflect the broad heterogeneity of the practice population. In keeping with sampling strategies in qualitative research there was no attempt to obtain a representative population but rather a range of types of patient attending the surgery. In the event, the sample chosen ranged in age from 20 to 73, with a cross section of local ethnic and social class characteristics. Four patients declined to take part, one phoned in unwell, one said she was too busy, one simply failed to attend, and the last was a male drug addict who "forgot" about the appointment.

The invitation to the interview included a copy of a handout that explained the objectives of the interview together with a ranked list of nine different services available in hospital and the community (derived from a study by Bowling *et al*³). The handout emphasised that the task would be to talk about why the interviewee thought that one service deserved greater priority than another. The interviewees were asked to return between two and three days later. The interviews took place at the surgery during the first six months of 1994. They were tape recorded and subsequently transcribed. Each interview took 30 to 40 minutes.

To identify important recurring themes in the interviews the transcripts were indexed numerically and analysed line by line. Themes identified from the transcripts were recorded on the vertical axis of a large grid with the transcript index on the horizontal axis so that recurrent themes from the whole sample could be identified. This form of analysis enables the concerns of the interviewees to emerge, rather than those of the researcher.⁴

Results

Although all respondents attempted to engage in the task of discussing their own priorities in relation to the list provided, they found it difficult. The list provided a point of departure and reference point for the interview but the main issues that emerged, and the ones reported here, related to the ways in which the task of priority setting was approached. For example, despite the initial request to think about how the list of services should be ordered, no interviewee was fully persuaded that the process of rationing or allocating priorities to health services should happen at all.

"Well for starters there shouldn't have to be these decisions to be made! For a start they should be able to put enough money in instead of spending it all on them other things, like going to war in the different countries."

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BMJ 1995;311:1137-9

On the other hand, there was a feeling that if it had to be done, it was not a job for themselves, but perhaps for someone else.

"Where I come from it's a working class area and you find that people aren't interested in what's going on around them at all. All they're interested in is getting through the daily grind of life and anything else outside, they'd just rather keep it outside, because they're having such a bad time anyway of getting through life and you find that they don't want to be bothered by it."

Doctors in general, and general practitioners in particular, were seen as useful advocates for the public. An unemployed school teacher believed that general practitioners were the focal point of their communities and therefore in the best position to reflect the needs of their patients. There was little support for the involvement of politicians in the process as they were judged too distant from the issues to be informed, and neither did they listen to the public.

"Yes, but the government doesn't listen to what the public think, that's the awful thing, you know, I mean because otherwise the health service wouldn't have become this 'shopping ground.'"

The notion of equity in prioritising services received widespread support. The idea that any individual or group within society could be more deserving than another was consistently denied; however, some age discrimination was evident. Paediatric services received wide support, but needs of the elderly received little sympathy. This was supported by the observation that most people's grandmothers would prefer resources to be spent on the young rather than the old.

"Services for the elderly and chronically ill, that's a complete drain on the National Health 'innit really, and doesn't actually get you anywhere 'cause it doesn't . . ."

Interviewees were very reluctant to justify their views on the basis of personal needs. In answer to a question about the influence of her own needs a middle aged woman with arterial disease said:

"No, I didn't even think of it that way. I guess because I am not half dying . . . I suppose maybe if I was . . . if I had suffered some way . . . but for me whatever I have needed I have got. But that doesn't mean everybody else does . . . I have seen people around me who have had to wait. I never even thought of myself there."

Equally, an elderly woman who felt threatened by the absence of local nursing homes, of which she was convinced she would have a need in due course, was apologetic in expressing her own needs:

"That's selfish probably, but it is very important as there aren't the residential homes . . . unfortunately there are so many of us . . . I think they are living so long . . . people living so long, it's dreadful."

The only time that a "personal" view was expressed was with reference to unsatisfactory experiences of a particular service. For example, when individuals felt personally let down or had witnessed other people not receiving a service for which they felt they had a need (particularly community services), then this was seen as a priority area. The corollary of this was that if a particular service was perceived to be fulfilling its current expectations then it became less of a priority. On the subject of community nursing a 20 year old pregnant woman said:

"I mean I'm not sure, 'cause I haven't really had much to do with that, but that seems to be a pretty good service already . . . obviously they could do with more money, and that, but like I think they do a pretty good job."

The single most important attribution that interviewees identified as a determinant of their opinions was contact with visible unmet need. This was expressed most frequently in the context of encounters

Prioritising health services: recurring themes

Difficulty of engaging with the task

Lack of acceptance that prioritisation should be necessary

Belief that doctors should act as the public's advocates

No faith in politicians' views on priorities

Bias against provision for elderly (not good value for money)

Reluctance or inability to voice personal needs

Importance of personal experience of a service

Importance of contact with visible unmet need

Importance of perceived needs of others

in the community with people who were psychiatrically ill, abusers of alcohol and those who were homeless and begging. Consequently there was a heightened awareness of the inadequacy of the provision of services to cope with inner city problems, including mental illness and local hospital closures.

In general, interviewees were more comfortable justifying their opinions on the basis of the needs of others. The apparent unacceptability of expressing priorities according to personal need seemed to be resolved by the altruistic consideration of others' immediate and potential needs. Even consideration of a personal need for a specific service in the future was usually expressed in the second or third person.

"If you happened to develop breast cancer or something and you hadn't been screened properly, then you would think that was probably more important at the time . . . everyone isn't completely selfless . . ."

The box summarises the recurring themes from the interviews.

Discussion

Despite published reports of how respondents would and would not allocate priorities to certain services, this qualitative study shows the difficulties surrounding the evaluative process. In part people seem to lack the confidence to make such judgments, but there also seems a strong scepticism about the need for choosing priorities in health care. This may be a result of the long history in Britain of health care being outside the market and therefore not subjected to its discipline of opportunity costs. Moreover, the paternalism inherent in the way health care has traditionally been provided may account for the belief that doctors remain the best equipped to make these difficult decisions—if they have to be made at all. (The confidence expressed by these respondents that general practitioners could make these decisions on their behalf may, however, simply reflect the particular circumstances of this study.)

The respondents' reluctance to use their own needs as a basis for determining preferences was balanced by the use of others' needs as justification for service priorities. This may be a rhetorical device to avoid appearing selfish or a genuine concern for the welfare of others, particularly friends and relatives. At the very least the unwillingness to claim personal needs as the basis of service preferences seems to reflect a continuing element of "social welfare" in thinking about health care. The internal market may be a reality, but these interviewees were reluctant to see themselves as direct consumers in that marketplace.

The importance of the needs of others was further brought out in the way that local salience influenced views. Certainly the needs of friends and relatives are likely to be known, but it is difficult to identify the

needs of others other than through everyday contacts and experiences "on the street." This emphasis on the local environment also found expression in the way that local hospital closures coloured assessments about health service priorities.

Overall, these findings challenge the idea that local voices should have great prominence in decisions about health resource allocations. These interviewees felt ill equipped to become involved in the process and were reluctant to give opinions based on self interest. This broad position might reflect the legacy of a paternalistic health service in which patients were disempowered, but it also means that consumer consultation exercises that use highly structured questionnaires must have doubtful validity. Although it might be possible to persuade respondents to tick a preference box, such a judgment seems to reflect more a perceived social ethos of equity rather than a personal view. Consumers may have an important part to play in the more consumer oriented NHS of the 1990s but until they can accept

that this role requires them to express personal preferences public consultation exercises are, ironically, likely to reflect a collectivist approach to health care provision.

This paper is based on work submitted for the masters degree in general practice at the United Medical and Dental Schools of Guy's and St Thomas's Hospitals, University of London (AD). The Royal Society of Medicine kindly contributed a bursary which defrayed the costs of secretarial time.

- 1 NHS Management Executive. *Local voices. The views of local people in purchasing for health*. London: Department of Health, 1992.
- 2 Heginbotham C. Healthcare priority setting: a survey of doctors, managers and the general public. In: *Rationing in action*. London: BMJ Publishing Group, 1993.
- 3 Bowling A, Jacobson B, Southgate L. Health service priorities. Explorations in consultation of the public and health professionals on priority setting in an inner London health district. *Social Science and Medicine* 1993;37:851-7.
- 4 Strauss A. *Qualitative analysis for social scientists*. Cambridge: Cambridge University Press, 1987.

(Accepted 19 September 1995)

Body fat distribution before pregnancy and gestational diabetes: findings from coronary artery risk development in young adults (CARDIA) study

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An increased waist to hip ratio is associated with abnormalities of glucose metabolism and an increased risk of non-insulin dependent diabetes mellitus.¹ We therefore prospectively tested the hypothesis that a greater prepregnancy waist to hip ratio might increase the incidence of gestational diabetes.

Subjects, methods, and results

In 1985-6, the coronary artery risk development in young adults (CARDIA) study examined 5115 adults aged 18-30 years from four communities in the United States.² Second, third, and fourth examinations were performed in 1987-8, 1990-1, and 1992-3. Pre-pregnancy risk factors assessed in 1985-6 included body mass index (in kg/m²), waist (minimal abdominal girth), and hip (maximal protrusion) circumferences. Fasting serum insulin concentration was measured by immunoassay.

At each examination participants reported whether they had ever had diabetes. Women also were asked about each interim pregnancy, including "Did you have diabetes during this pregnancy?" No attempt was made to validate this self report of gestational diabetes as this was an analysis of an existing data set.

Of 1083 women who reported pregnancy during the seven years between the baseline and fourth examinations, 56 reported gestational diabetes. We excluded women with a history of diabetes or pregnancy at baseline, a pregnancy of less than 25 weeks, a multiple pregnancy, or missing gestational diabetes status, leaving 720 women, 44 of whom reported gestational diabetes.

Cumulative incidence (the number of women who reported incident gestational diabetes divided by the number of women who became pregnant) was calculated within thirds of baseline anthropometric data. Relative risks were calculated by unconditional logistic regression (SAS Institute, Cary, North Carolina).

Of the 720 women, 48% (346) were white and 52% (374) were black; at baseline, 63% (454) had > 12 years'

education; 16% (115) reported diabetes among first degree relatives; 39% (281) were parous. Age adjusted relative risks of gestational diabetes were significantly raised ($P < 0.05$) in the highest versus lowest third of baseline weight (relative risk=2.23), body mass index (2.49), waist circumference (2.31), hip circumference (2.44), and fasting serum insulin concentration (2.66), but there was no dose-response pattern. In contrast,

Multivariate adjusted relative risk of gestational diabetes in relation to baseline prepregnancy body mass index, waist to hip ratio, and other covariates; coronary artery risk development in young adults (CARDIA) study, 1986-93

Baseline characteristic	Model 1* Relative risk (95% confidence interval)	Model 2† Relative risk (95% confidence interval)
Body mass index (kg/m ²):		
14-18-22-14	1.00	1.00
21-14-24-12	0.98 (0.40 to 2.43)	1.23 (0.47 to 3.22)
24-14-53-53	1.94 (0.83 to 4.54)	1.99 (0.76 to 5.19)
	Trend P=0.113	Trend P=0.164
Waist to hip ratio:		
0.629-0.705	1.00	1.00
0.706-0.742	2.74 (1.02 to 7.35)	2.28 (0.83 to 6.25)
0.743-1.020	4.02 (1.50 to 10.77)	3.00 (1.08 to 8.35)
	Trend P=0.004	Trend P=0.02
Age:		
<20	1.00	1.00
20-24	0.95 (0.29 to 3.12)	0.96 (0.29 to 3.22)
≥25	1.21 (0.38 to 3.87)	1.35 (0.41 to 4.43)
Race:		
White	1.00	1.00
Black	0.55 (0.27 to 1.12)	0.52 (0.24 to 1.12)
Family history of diabetes in first degree relatives:		
No/unknown	1.00	1.00
Yes	2.89 (1.42 to 5.88)	2.78 (1.34 to 5.75)
Parity at baseline:		
0	1.00	1.00
1	0.86 (0.42 to 1.78)	0.81 (0.38 to 1.74)
>1	0.14 (0.02 to 1.12)	0.15 (0.02 to 1.15)
Fasting serum insulin concentration (μU/ml):		
2.5-6.7		1.00
6.8-10.8		0.70 (0.25 to 1.91)
10.9-67.1		1.82 (0.74 to 4.47)
		Trend P=0.144

*Model 1 included dummy variables for thirds of body mass index and waist to hip ratio, age (<20, 20-24, ≥25), race (black/white), family history of diabetes in first degree relatives (yes, no/unknown), and baseline parity (0, 1, >1).

†Model 2 also included fasting insulin.

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BMJ 1995;311:1139-40