

How do we measure up?

In September 2011 I had the pleasure of leading a GPNZ Study Tour to North America. Our group included nine GP and executive management leaders from ProCare Health, Whanganui Regional PHO, Pegasus Health, GPNZ and our Patients First programme.

The objectives of the Study Tour were to evaluate models of health care service delivery and associated quality and information frameworks in Canada and the USA, identify exemplar systems and methodology and consider the feasibility and value of development and implementation within NZ Health Care Networks.

The best airline in the world (Air NZ) delivered us safely to Vancouver BC – a very attractive city with a population of 600,000 and beautiful, balmy autumn weather. Our first port of call was to Intrahealth Canada where Managing Director Mark Matthews provided an overview of the Canadian health system in general and health information development in particular. Mark presented Intrahealth's integrated network platform/health information capability – the irony of a group of kiwis going all the way to Vancouver to see another kiwi present a kiwi developed platform was not lost on us!



View from Mark Matthew's office in Vancouver which may explain why he spends so much time in Canada.

The Canadian health system is almost exclusively fee for service (FFS) and services are free to all Canadian citizens (although pharmaceuticals are not free). The philosophy around a publically funded health system is enshrined in their legislation to the point where it is illegal to provide a private service if it is on the funded schedule. There is huge federal and state investment in health IT through Canada Health Infoway.

We were pleased to have the opportunity to renew our collegial relationship with Drs Brenda Hefford and Brian Elvoy (who spoke at the World Health Networks Conference in Auckland last year) and visit their Family Practice in White Rock. Much of what we saw was similar to the NZ general practice model but three main differences struck us:

- The FFS model is applicable to doctors only and this significantly limits the development of nursing partnership
- In a "full service" Family Practice GPs care for their hospitalised patients (GPs do ward rounds)
- No enrolment with Family Practice limits ability to meaningfully engage in population health initiatives

The next port of call was Seattle where we joined a Kings Fund Study Tour for a week. The NZ contingent was augmented with clinical and executive leaders from Compass Health and Rotorua Area Primary Health Services (RAPHIS)/RGPG for this part of the tour.

Well what an eye-opener the US health system is! We learnt that what we describe as a “public health system” in NZ the Americans describe as “socialised medicine” which was not politically palatable in some quarters!

We saw the best of the best (and the not so good eg. large numbers of homeless vets) but with a predominantly hospital focus. We saw some inspirational examples of:

- fully integrated delivery systems
- “triple aim” based quality measures frameworks
- use of national benchmarking measures
- patient experience of care measurement
- transparent and near real-time information supporting quality
- investment in primary care infrastructure
- co-investment in social determinants by local authorities
- tele-health and remote monitoring systems
- patient empowerment / self care programmes



Kings Fund Study Tour at Wenatchee (rural area near Seattle) where we saw an outstanding telehealth initiative .

Although recognising it is now a matter of scientific fact that a primary care based health care system is the only system that can affordably provide quality care to a population, the drivers of the US health system are focussed around hospital level care. It is almost an exclusively FFS system and the culture of litigation drives high volumes of diagnostic testing. We were overwhelmed at the number of MRIs available and their frequent use.

The US political system is complex and multi-faceted. It was difficult to understand how they could implement the type of workforce, pay and liability reforms required to re-focus the system around primary care with such a strong lobby from the big insurers and pharmaceutical companies. We were interested to learn the Fortune 500 companies formally recognised the value of family medicine and have signed an “accord” with the American Academy of Family Physicians. IBM is leading the charge around finding every employee a “medical home”.

At the end of the Kings Fund Study Tour component the group met at Salish Spa (a venue near Snoqualmie Falls) where we had the opportunity to review and discuss what we had learnt from the various organisations we had visited in Seattle and distil some key themes. In being exposed to other health care systems what we learn and validate about ourselves and our own system is just as important as the

opening of our minds to new ideas. There are so many components of the NZ health system we all agreed were key enablers:

- Patient enrolment – knowing your population and having accountability for that population
- Blended funding model – key enabler of innovation and flexible workforce models eg. nursing partnerships
- Primary care infrastructure – 20 years experience of clinically led health care network support capability
- PHARMAC and ACC – we take them for granted but they are national treasures!
- Health information systems – world leaders in both adoption and use
- Whanau ora – national adoption of a holistic model combining health and social care

and probably most importantly from a patient outcome (and economic) point of view:

- A well developed NZ model of primary care medical and nursing “generalism”.

The group of thirteen from NZ (from five networks, GPNZ and Patients First) then had an opportunity to work together in a group and consider what key themes and learning we believed were applicable to (and priorities for) the NZ environment.

We noted that without exception all the health organisations the group visited had highly developed and integrated quality, measurement and credentialing frameworks. Patient Experience of Care survey tools were used extensively as a key driver of change.

Timeliness and transparency were key features of information used for measurement and were prioritised higher than accuracy of information (accuracy appeared to take care of itself as soon as the information was used for benchmarking!).

We were impressed with the use of the IHI Triple Aim as a framework for grouping and presenting quality activity and this links well with the NZ Health Quality and Safety Commission’s (HQSC) variation of the Triple Aim. We noted the organisations we visited also had a fourth dimension of measurement around workforce which they gave equal weighing. This was less about the quantum of the workforce and more about the professionalism and degree of alignment with the culture of the organisation.

The NZ contingent has agreed to explore the concept of a “Quality Quadrant” (Q4) within NZ health care networks using a combination of the HQSC’s version of the Triple Aim and a fourth dimension around workforce. This will be explored purely as a framework in which to group quality measures and present quality information and we will use our existing National Health Target measures and PHO Performance Programme measures to test the model.

As a health care system NZ has “good bones” and in many respects we remain world leaders. If we take the best of what we already have and apply some of the learning from exemplars in other countries we really do have the potential to be the best (Rugby World Cup included).

Do we measure up? Absolutely - but the best is yet to come! Watch this space.....