



## Measuring the quality of general practice in New Zealand

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The quality of the service provided by a general practice is the degree to which it conforms to some kind of standard of care.<sup>1</sup> In New Zealand this standard has been developed as part of a framework comprising a set of activities with the common objective of improving the quality of care provided by general practices. The Royal New Zealand College of General Practitioners (RNZCGP) recently developed a framework for measuring quality. It measures factors that affect patients, physical factors affecting the practice, practice systems, practice and patient information management, quality improvement, and professional development.<sup>2</sup>

### Why measure quality?

The merits of measurement have been argued since Donabedian first introduced the concept that quality could be assessed by evaluating the process measures or outcome measures of a health service.<sup>3</sup> A focus on process measures is preferable in general practice. It measures the quality of various activities undertaken from when a patient decides to visit a general practice for healthcare, through the encounter with the practice, and onto the care provided when the patient returns home.<sup>4</sup> The performance of the practice in each of the various activities can be compared with a standard that enables a target for quality improvement to be achieved. The experience of outcome-based measures of quality has not been very successful in the primary care sector for two reasons.<sup>1</sup> First, the health status of individuals may be determined by several factors other than the quality of the general practice service, namely the severity of the illness, or the state of health before treatment. Second, it is difficult to collect accurate information of disease outcome among a practice population of individuals with multiple, complicating diseases.

The tool developed by Gillon et al, the trial of which is described in this issue of the NZMJ, provides a credible process measure of the quality and safety of a general practice.<sup>5</sup> It contains 46 indicators that can be achieved by meeting certain criteria required by legislation and other criteria determined as essential by the RNZCGP. The use of this tool will pick up the minimal acceptable standard below which no general practice should fall (for example, the embarrassing finding in the 1970s of general practices that had no wheelchair access nor toilet facilities for patients<sup>6</sup>). The tool also allows for the development of achievable standards. These are levels of performance that can be a target for quality improvement. For example, a general practice might find that it did not meet the major criterion of the enhancement of privacy through the practice reception layout. This would become a target for improving the quality of the design of the reception area in future refurbishment.

### What needs to change?

Many of the practices in the study by Gillon et al were anxious prior to the evaluation of the quality of their practice.<sup>5</sup> I can only speculate that their anxiety was a consequence of the mistaken belief that the evaluation of their practice was equated to

the evaluation of themselves as individuals. In New Zealand we often use the words 'general practice' to refer to the individual general practitioner and their general practice as one and the same. This confusion came to light in the late 1990s when the RNZCGP commissioned a nationwide survey asking its members to describe the characteristics of their own work and their practice.<sup>7</sup> In that survey, about one third of general practitioners were the only medical person working in their practice. However, a number of general practitioners claimed they worked in individual general practices even though they worked with general practitioners who used the same practice title, address, and telephone number. The word 'quality' could also contribute to the anxiety because it can refer to many things: the quality of an individual's clinical work, the quality of a practice's infrastructure, or the quality of the economic environment. Anxieties about evaluating quality need to change. One way would be to separate the concept of the quality of a practice from that of the quality of the individual practitioner.

### **Why use a tool for evaluating quality?**

In New Zealand most general practices are by their very nature small-scale businesses with about five people working within the premises.<sup>7</sup> In such a small environment it is easy for everyone to have a sense of knowing what is happening within a practice. Why would they bother to tick hundreds of boxes in an evaluation form to demonstrate what they know already? This attitude does not fit well with the notion of continuous quality improvement of a primary care system.<sup>8</sup> A practice will not be able to proclaim it provides quality of care if it does not use a validated tool to demonstrate that it conforms to a standard of care. The framework for implementing the quality tool developed by Gillon et al provides practices with a measure to assure themselves, and their local community, that the practice is continually improving the quality of its primary care.<sup>5</sup> The tool also allows organisations such as the RNZCGP to claim that there is evidence in New Zealand – other than anecdotal – that general practices provide highly valued health services to local communities.

Gillon et al did not provide an economic analysis of the compliance costs of maintaining quality.<sup>5</sup> These costs will need to be considered whatever political perspective is taken of general practice, either as a small-scale business venture or a small-scale health service providing primary care to a defined practice population. Gillon et al described two major contributors to the compliance costs of quality. First, some practices did not take the responsibility of measuring practice quality seriously. The evaluation of quality was not successful in these practices either because they did not complete the self-assessment prior to the arrival of the evaluation team or some members of the general practice did not contribute. Second, many general practices did not have transparent information systems that made it easy for the evaluation team to determine the quality of their medical records. The cost of obtaining cooperation for people to measure the quality of their practice, and the cost of making practice information systems comparable are both high. Gillon et al found that small and rural practices in particular thought that cost recovery for assurance was a concern. Adequate resources and funding are essential if practice teams are to engage in the measurement of quality of general practice in New Zealand.

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