Health and communities

By General Practitioner Council Chair Dr Kate Baddock

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How do we determine the health improvement of a community? How do we gauge whether what we are doing is altering the health outcomes for a community or a population? How do we know whether health programmes have an impact?

These are issues which tease the best minds in the land and occupy an inordinate amount of energy for policy makers trying to ensure that the public funding which finds its way through PHOs to General Practices and to patients – not necessarily in that order – is making a difference to health outcomes.

Part of the problem is that prior to the implementation of the Primary Health Care Strategy there was not a system in place to determine the health level of a community. We didn't know who in our enrolled population accessed emergency care, or why or how often. We didn't know (easily, if at all) how many in our enrolled population had diabetes and were being checked, or were having cardiovascular health checks. And so on. On an individual basis as doctors we knew our patients and what we were doing for them, but we didn't know our population. Now we have tools in place to know these things. Population needs analysis is opening the eyes of General Practice and the PHOs to information that has the potential to change health outcomes in ways that have not been possible previously.

As we all know, the PPP programme measured processes not health outcomes. It was argued that what could be measured, should be measured. The word 'outcome' referred to performance indicator outcomes rather than health outcomes, of which there were many. Peter Crampton, in his article in the NZMJ in 2004, teased out many of the issues around how we should determine those process indicators[1]. Since those times there has been a developing maturity in the thinking that now recognizes that health outcomes are the more important issue – something that doctors have always known. Many doctors have been in their practices for 20 years or more, and this longitudinal association means that we are very aware of real health outcomes. How we practised medicine 20 years ago for an individual patient has an impact now on the health of that patient. Patients are individuals, but individuals make up populations. Take diabetes for instance – a hot topic since the Minister has just announced alternative ways of using the funding previously directed to the Diabetes Get Checked programme. We as doctors know that measuring the HbA1c is a process measure rather than an outcome measure. Some of the more important outcomes might be blindness, due to diabetic retinopathy, or renal failure necessitating renal dialysis due to diabetic nephropathy and blood pressure control. How many patients do I have as a doctor that I have been treating for diabetes for the past 20 years that now have progressive renal failure, or major diabetic retinopathy? If we were to measure those kinds of health outcomes we would really know whether we were making a difference.

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[1] Crampton et al, NZMJ 2004 Vol 117 No 1191

In terms of the Diabetes Get Checked programme, it ran for five years and the funding has now been withdrawn in favour of alternate strategies – yet to be announced. The value of the programme may not have been in the reduction (or not) of the HbA1c of those within the programme but rather that there was a programme in place. By having a Diabetes Get Checked programme, awareness of diabetes care and management in general was enhanced. I would suggest that General Practice improved its care of all those with diabetes – whether part of the programme or not – simply because the programme existed. Programmes have their value not so much in what they do (ie their content) but by their very existence.

So, if programmes are at least partially successful simply because they exist, does their content matter? And as a corollary to that, does it also matter how much the programme is used? The value of the programme has to be whether it makes a difference to the health outcome of the community and the only way that can be identified is to know what the health outcome was before and after – and this is where population health analysis is critical. PHOs and other Primary Care organizations have the capability to do this as they have the enrolled population data. Without this information we are powerless to know whether we have made a difference. It is not enough to measure the numbers of patients who use a programme, it is not enough to measure the direct results ie HbA1c.

It is only enough when we know whether health outcomes are improved.