Opening the tin reveals what general practice has achieved

18 June 2014

We are close to getting a clear view of health data and how they vary from practice to practice, writes Kate Baddock.

“Tin openers” is a phrase used, albeit not coined, by the Health Quality & Safety Commission.

But what is a tin opener and what does it all mean for general practice?

The commission was established under the New Zealand Public Health and Disability Amendment Act 2010 to ensure all New Zealanders receive the best health and disability care within available resources. It is also working toward the New Zealand triple aim for quality and safety outcomes, by which it means improved quality, safety and experience of care; improved health and equity for all populations; and better value for public health system resources.

In recent times, the commission has been focusing on its Atlas of Variation project, designed to provide a view of the variation across, initially at least, hospitals and DHBs.

The atlas is a suite of tools and measures to compare variation in clinical domains, for example, tonsillectomies and grommet insertions.

The approach has not been designed as a league table for judgement purposes, but rather to stimulate clinical dialogue around variation. It’s therefore known as a tin opener.

The problem is how to define variation in medical practice. As the commission said in a paper last year, this often “cannot be explained by demographic factors or other determinants of health need and, as such, has provoked questions about effectiveness, efficiency and quality of health services.

“Observations of variation have consequently been used to justify a variety of policies aimed at reducing variability, such as greater emphasis upon outcomes research, feedback to practitioners, and closely monitored performance measures.”

And that brings us to general practice. The Atlas of Variation project is being widened to include primary care, with the development of tools to assist clinicians in comparing and contrasting their patient cohort relevant to a variety of measures.

Readers who have been working toward health targets will be aware there are tools, such as Dr Info, that can run a query on your data via the practice management system, to find out how many immunisations are done by eight months or two years of age, how many cardiovascular disease risk assessments have been completed for particular age groups, and so on.

PHOs already use this data to inform themselves as to which practices are performing well and which are not doing so well, so they can provide support where needed.

This is practice-level variation – some of which will be warranted and some of which will be
unwarranted (ie, not explained by demographics or other determinants of health need).

We are about to enter an era where this level of variation will be available to all the practices within a PHO. Can you envisage the clinical discourse between clinicians discussing variation and what it means for their own practice? This kind of conversation has the power to change our clinical behaviour in many ways. Tin openers everywhere!

But we need to move from health targets to health outcomes. Outcomes often have more relevance for clinicians, eg, bowel cancer, depression, or prostate cancer. Imagine the value in being able to look at, in terms of variation, the (appropriately anonymised) incidence of prostate cancer, its management and mortality at the level of practitioners, practices and PHOs throughout New Zealand.

The value in understanding variation cannot be underestimated if we are to achieve the Triple Aim for all New Zealanders.

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