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EDITORIAL

HealthPathways website: making the right thing the easy thing to do?

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Two papers in this edition of the *Journal* report enthusiastically on HealthPathways in Canterbury—"a website that provides general practice teams with guidance on clinical assessment and management of medical conditions, relevant to local services and resources".[1] One paper reports a user survey of health professionals (but not patients).[2] The other paper describes the history, processes and some results.[1]

HealthPathways grew from a need for an "integrated healthcare system", which would reduce demand for secondary care services, and a recognition that redesigning the interface between primary care and secondary care was essential to reach this goal.[1]

Providing best health care can be considered in two components—determining the right thing to do, and making sure this happens. The first can be embodied in evidence-based guidelines and the second in implementing these. Implementation almost always requires changing human behaviour—frequently that of health professionals. It is commonplace to see high quality guidelines with poor implementation, and system changes that are not evidence-based.

Integrated care is variously defined, but the central element is always care that is coordinated over time, place and care provider.[3] Requirements to achieve this are also variously listed,[4] but here we emphasise elements derived from the Chronic Care Model[5,6] and re-articulated by Ham:[7–9] improving organizational and professional relationships, distributive leadership (beyond the heroic individual), linking health and social services, supporting patient self-management, using health information and communication technologies including data monitoring and management, and linking these within an overall system of care. We will consider HealthPathways against each of these criteria.

The survey respondents are clear that HealthPathways has improved organisational relationships between primary care and secondary care, and professional relationships between general practitioners and hospital specialists. This is likely to be due to the process of developing the pathways more than the product, but reinforced by mutual use of the product. Similarly, distributive leadership is embodied in the process, and is embodied in the use of the product within which individual clinicians standardise their work.

The language of HealthPathways refers to linking primary care and community care, but the scope of community care is not defined. In a New Zealand context this is generally constrained to referrals to allied health professionals. The language of the Chronic Care Model and primary health care go well beyond this to include specific focus on links to social services and care,[8] and beyond this to social determinants of health.[10,11] Results from links to narrowly-defined community care will always be limited to more-of-the-same.

The patient voice is not obvious in the HealthPathways process or the assessments reported. Patient education material is built into the system but is for the convenience of general practitioners and practice nurses. Consultations using HealthPathways are thought to take a little longer. More time is generally considered positively by patients, but the report authors interpret this as negative from the presumed viewpoint of general practitioners and practice nurses.

Advanced use of information and communications technology is central to HealthPathways. So, it seems, is embedding HealthPathways in a process that is clearly defined, adequately funded, socially and professionally acceptable to the stakeholders and set up so that professional writers and technology supports the output agreed by stakeholders, rather than the other way around. All the right

priorities, all regularly ignored elsewhere. Apart from routine audit of HealthPathways processes, the authors point to the potential to monitor unmet need for secondary care services. This would require primary care to refer everyone who they think needs care, rather than limit referrals to those they think will be accepted. We think this is desirable but unlikely in practice as it would presumably take additional time from primary care and, in any case, the pathways by definition are defined around local service resources.

Is HealthPathways embedded within a wider, coherent and managed system of care? This is not known from the reports offered and would be an appropriate subject for further study. We have seen presentations from Canterbury that demonstrate the intention to take a systems view of health care and links to social services.

We are aware of ambitious work on a summary medical record based on the primary care record and accessible to an increasing number of health care professionals involved in the care of a given patient (electronic Shared Care Record). This Record is also provider-centred but does have strong patient privacy protection built in.[12] There are plans that eventually patients will be able to view their own record. Compared with what we are aware of currently, a full systems approach might include a patient portal, more developed support for patient / whanau self-management, more active data management and quality control across primary and secondary care, and a systematic population health programme using both a counting-individuals approach and a determinants-of-health approach.[13]

We think both papers go beyond the data they provide to produce strong conclusions in support of HealthPathways. Having said that, we think the data provided is sufficiently strong to congratulate the many people—and commend the distributive leadership approach adopted—who have made HealthPathways a success. We are sure they would agree that their job is not finished … and it never will be.

Determining the right thing to do is, dare we say it, relatively straightforward inasmuch as the process of creating and synthesising evidence is relatively well-developed. The science of implementation, making sure the right things are done, is less well-developed. Evidence-based guidelines attempt to identify "universal truths" about what should be done. Implementation is local and requires statements about who does what and when. Little implementation occurs by diffusion of (cognitive) evidence; it is more accurately portrayed by theories of professional dominance[14] and spread of ideas by socialisation.[15]

Given the longstanding history of poor- or non-relationships between health professionals in New Zealand, particularly across the divide between primary care and secondary care,[16] it is not surprising that Canterbury addressed this issue as central to their quest for integrated care. Others have identified and addressed the same issue, often without the degree of success that Canterbury appears to have achieved.[16]

One of the many challenges for Canterbury will be—having addressed issues of professional dominance by starting with general practitioners and hospital doctors as central to developing HealthPathways—that they do not continue to reinforce inappropriate professional relationships. Medical dominance poses an obstacle to interprofessional cooperation and may reduce the contribution of nurses and allied health professionals. Best care is provided by teams.[17]

HealthPathways is popular and widely used in Canterbury and the process, together with most of the pathways, has been taken up by an increasing number of other health providers in New Zealand and Australia. Presumably health care providers find it easier and/or more useful than their alternatives. The ideal of implementation is to make the right thing to do the easiest thing to do.

HealthPathways seems to have successfully developed a process that makes using their product the easiest thing to do. The authors have so far produced little evidence to confirm that their product is the right thing to do. We are not implying doubts about patient benefit or harm, but merely point to the

considerable work remaining and needing to be done to prove effectiveness, cost effectiveness and equity with data that go beyond provider impressions and indirect or process indicators.

Competing interest: Nil.

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