Quality improvement within Independent Practitioner Associations: lessons from New Zealand

Neil Houston, General Practitioner and Associate Adviser, Dollar Health Centre, Dollar, United Kingdom; Gregor Coster, Elaine Gurr Professor of General Practice, Division of General Practice and Primary Health Care, Faculty of Medicine and Health Science, University of Auckland, Auckland; Linda Wolff, Consultant Psychiatrist, Forth Valley Primary NHS Trust, Larbert, United Kingdom.

Abstract

Aims. To ascertain what quality improvement activities are being performed by associations of general practitioners (GPs) in New Zealand, to find out how they are supporting these activities, and learn about their experience of the process.

Method. A cross sectional questionnaire study of 25 independent practitioner associations (IPAs) in New Zealand.

Results. All respondents (n=25) believed quality improvement was a responsibility of their organization, and for 48% it was their highest priority. All organizations carried out and supported a range of quality improvement activities. The major perceived barriers to quality improvement were negative attitudes and lack of time and money to support the process. Strategies to overcome these barriers included providing comparative data to staff in a peer group setting and providing financial incentives, management support and education.

Conclusions. Considerable quality improvement activity is occurring in primary care in New Zealand. A variety of barriers to the process and methods of overcoming them have been identified by some, but not all IPAs.

IPAs have become an important feature of New Zealand’s primary care system since the 1993 health reforms. They were formed by GPs to protect and enhance the status of general practice and negotiate funding contracts with government bodies. Many have taken on budgets for laboratory and pharmaceuticals services. As they have developed, their goals have extended to include providing better quality health care to their patients and developing integrated services with other providers. In the future, contracts with IPAs will contain greater emphasis on quality and encourage organisations to implement continuous quality improvement programmes. Performance will be measured using a variety of methods including clinical audits and performance targets.

Improving quality in primary care is difficult, and approaches including clinical audit, guideline implementation, quality improvement programmes, and total quality management have identified many barriers to the process. The conditions and resources required for quality improvement do not commonly exist in primary care.

The aims of this study were to find out how IPAs were improving quality, to learn about barriers to the process and how they could be overcome, and discover lessons from their experience which would be useful to colleagues as they strive to implement continuous quality improvement.

Methods

We conducted a cross sectional questionnaire survey of IPAs throughout New Zealand in January 1999. A 22 item questionnaire, containing mainly open questions was developed (see headings in Results section: full details available from the authors upon request). A database of all IPAs in New Zealand was obtained, containing details of 40 organisations. Each organisation was telephoned by NH and had the survey explained. Following this 32 IPAs were identified as suitable to receive the questionnaire. Three did not consider themselves an IPA and five had merged. An individual responsible for quality issues in each IPA was chosen to receive the questionnaire. Twelve IPAs (48%) indicated that they considered addressing quality issues as their highest priority.

Approach to quality improvement. IPAs were asked to describe their organisation’s approach to quality issues. Seventeen (68%) indicated they followed a Continuous Quality Improvement approach, six (24%) a system of Total Quality Management and two IPAs were not sure how to describe their approach.

Quality improvement activities. IPAs were involved in a variety of quality improvement activities including; education of staff (96%) and GP members (92%); guideline development (92%) and implementation (84%); rational prescribing initiatives (84%); peer review (84%); patient satisfaction surveys (64%); clinical audit (64%); and developing quality standards (64%).

Support for quality improvement. IPAs supported quality improvement in various ways (Figure 1). 96% of IPAs supported peer group meetings of GPs, whose functions included education (80%), guideline development (60%), communication between the IPA and its members (56%), and peer support and review (52%). 56% of IPAs funded GPs to attend these peer group meetings. Pharmacists developed prescribing and disease management guidelines, and facilitated peer group meetings. 96% of IPAs provided resources for information technology including software support (60%), data extraction (40%), an intranet (24%), purchasing of equipment (16%) and training (12%).

GPs were involved in developing the quality agenda in 60% of IPAs through peer group discussions; representation on quality committees; surveys; newsletters; and open meetings to set priorities for the quality programme to which all primary care staff were invited.
The importance of education was emphasized by "by far the most potent motivators are peer review with hard data. Supplying doctors with comparative data from the changes being implemented, choosing "topics that GPs find achievable" and involving all members of the organisation in the daily activity. It is an overall strategy focusing on the needs of patients and involving all members of the organisation in the process through multidisciplinary teamwork and education.

Views on barriers to quality improvement. Figure 2 summarises the identified barriers to improving quality within IPAs. The most common barriers identified were lack of leadership (20%), a contractual obligation (16%) and developing procedure facilitation of peer groups, resources for information technology and educational meetings however, was taking place outside of resources (44%), shared long-term goals (20%), leadership (20%) and communication (16%) were also seen as strengths in a few IPAs.

Discussion

78% percent of identified IPAs were surveyed, which is similar to a previous IPA study (80%). The respondents were representative in terms of size, geographical distribution and demographic characteristics. The organisations covered 70.5% of GPs12 and 82% of the New Zealand population. The results can therefore be generalised to all IPAs in New Zealand. All respondents had responsibility for delivering quality services in their IPA. The views of individual GP members were not surveyed although 36% of respondents were practising GPs. The other respondents were management staff within IPAs.

All respondents saw improving the quality of services they offered as a current aim and 48% stated that addressing issues of quality was their IPAs highest priority. This compares with a previous study1 where improving the standards of general practice was seen as an IPA’s most important goal by two out of 38 respondents (5%). It indicates, therefore, that quality improvement is an increasingly important and common role for IPAs. Many IPAs felt that their approach to quality issues was one of Continuous Quality Improvement, which aims to “design quality in” rather than “inspect errors out”, as part of normal daily activity. It is an overall strategy focusing on the needs of patients and involving all members of the organisation in the process through multidisciplinary teamwork and education.

To achieve their goals, they were actively supporting quality improvement through a range of interventions including staff education, implementation of guidelines, patients surveys, the development of quality standards and involvement of GPs members. The authors believe that such activities occurred only sporadically in New Zealand before the development of IPAs. Furthermore, the resources provided by IPAs, including facilitation of peer groups, resources for information technology and pharmacy facilitators did not commonly exist previously. Much of their quality-related activity, for example peer groups and educational meetings however, was taking place outside of working hours and was funded inconsistently.

The study has highlighted a number of barriers to quality improvement in primary care previously identified by research into this field. Studies relating to the implementation of quality assurance and medical audit revealed similar negative attitudes held by GPs to those in this study, and attempts to introduce a systematic approach to quality improvement in primary healthcare teams also highlighted the obstacles of lack of time, skills, knowledge and financial support shown by this study. These studies additionally emphasised that reluctance to assess patients needs, lack of leadership from GPs and the lack of a reward system, impede the implementation of quality improvement in primary care. Grol et al found lack of collaboration between members of practice teams was a major hindrance to quality improvement, whilst others discovered that existing hierarchies within primary care interfered with the democratic teamwork necessary to bring about change. Only a minority of respondents in the study identified lack of teamwork and leadership and reluctance to assess patient’s needs as obstacles to quality improvement, contrasting with previous work which has highlighted their importance. Perhaps failure to

View on overcoming the barriers. Respondents identified building on the professionalism of staff (80%) as key to motivating their members and overcoming barriers to quality improvement. They could do this by ensuring patients benefit from the changes being implemented, choosing “topics that GPs believe are worthwhile in terms of patient gain,” and showing “how implementation of advice can improve care of patients” as powerful motivators. Supplying doctors with comparative data on their activities within peer groups was also useful (48%) since “by far the most potent motivators are peer review with hard data to back it up”. The importance of education was emphasized by many (40%) “best practice should evolve from regular and high quality continuing medical education and not by decree”.

It was felt that staff were encouraged by financial incentives (60%) either as a bonus, or through compensation for time spent on programmes. Money was not however, seen as the prime motivator to improve quality “money helps but is not top of the list”. In addition, management support (48%), additional resources (44%), shared long-term goals (20%), leadership (20%), a contractual obligation (16%) and developing teamwork could all facilitate the process of improving quality.

Figure 1. Responses to question: “how does your IPA support quality improvement?” (n=25)

Perceived strengths of quality initiatives. The main identified strengths of the IPA’s quality initiatives were, involvement of staff (64%), “GP initiated and run”, and a bottom up management style (44%), “don’t try to manage a top down process-you’ll only succeed in a minimum standard approach”. In addition, choosing relevant achievable goals (32%), focusing on guideline implementation (28%) rather than guideline development, education and training (24%), peer group activities (20%), leadership (20%) and communication (16%) were also seen as strengths in a few IPAs.

Figure 2. Responses to question: “what do you feel are the barriers to improving quality in your IPA?” (n=25)
recognition these obstacles has obstructed their attempts to bring about the desired change within their organisations. It is vital, therefore, that IPAs are aware of all the potential barriers to quality improvement and develop ways of overcoming them.

Previous studies have identified education, management support, provision of comparative data, and rewards as important ways of overcoming barriers and motivating individuals, thus supporting the beliefs of many respondents in this study. The powerful effects of providing comparative data to individuals in a peer group setting, building on doctors’ professionalism and their wish to enhance patient care have not previously been highlighted. Respondents, however, did not commonly acknowledge other interventions which are known to facilitate quality improvement including providing protected time for programmes, assisting the development of medical leadership skills, assessing patient needs, and creating long term goals and teamwork within practices, as noted in previous studies.

IPAs might increase their effectiveness by building on the professionalism of their staff and providing appropriate management support and education. They should consider setting up and facilitating peer groups and developing information technology systems to provide comparative data to staff on their activities. They should not underestimate the importance of training leaders, involving patients and promoting practice teams using recognised interventions such as away days, protected time for practice meetings, external facilitation and multidisciplinary training.

Finally, health authorities in New Zealand need to be made aware that improving quality in primary care is difficult and that if it wishes to implement continuous quality improvement, it should work with GPs to identify strategic goals, incentives and extra resources to enable IPAs to flourish.

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Correspondence. Dr Neil Houston, Dollar Health Centre, Park Place, Dollar FK14 7AA, United Kingdom. Email: nmhouston@msn.com

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