

## What makes a good PHO?

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Is a good PHO one that is fiscally sound and has reserves in the bank? And, if so, how much should there be in reserves? Or is it one that has significant uptake of its programmes (which means there would be less in reserves)? Or is it one that meets the targets in the PHO Performance Programme (this one may be of greatest interest to the DHBs and the Ministry of Health? Or is it the PHO that simply asks itself these kinds of questions and actually tries to answer them?

By asking questions like the above, a PHO is seeking to find its value and not merely assuming that by its very existence it has value. It seems timely to ask these questions and provoke public debate if appropriate.

To explore the first, it must be remembered that a PHO is a social enterprise and it is acknowledged that the contingency reserves required of social enterprises are not as extensive as for commercial companies. So is it the PHO acting as a healthcare organiser/supporter with “money in – money out” with just enough to survive? Or a banking organisation – building cash and capital assets?

The Ministry of Health in the Primary Health Care Strategy (2001) identified some basic principles that a PHO had to adhere to in terms of its structure, its governance and its performance, but it didn't define the question asked above. It required a PHO to be not-for-profit but that was the only reference to its financial arrangements. As a consequence, PHOs have set their own internal criteria or where they see themselves and to what extent they feel it is fiscally prudent to establish reserves. As the monies that come to PHOs are public funds, there is a need for transparency and clear accountability in establishing those criteria.

The uptake of programmes and meeting the targets of the PPP are overlapping issues. There is a significant body of evidence that suggests meeting targets may be fiscally driven and this is particularly apparent in the UK where gaming may be the norm in order to meet targets.

When the UK Government determined that 100 per cent of patients be offered an appointment to see the GP within two working days, the practices placed a restriction on booking so nobody could book more than two days in advance.<sup>1</sup> In the same article, the authors argue that a centrally targeted set of performance indicators is flawed as some indicators are “dials” where a good measure exists (in New Zealand an example of this may be the classification of smokers) but a larger set of indicators are “can-openers” in that they answer, providing an incomplete and inaccurate picture (in New Zealand HbA1C is a good example of this), and an even larger part of performance for which there is no usable data at all. So we end up measuring that which can be measured, not that which is important.

Further, there is likely to be gaming taking place in order to meet targets that may not event matter. So, is a PHO that meets its health targets a good PHO, or merely one that plays the game well? The uptake of programmes by practices and GPs is related by not the same.

Not all programmes are driven by the PPP, although there is usually a component that may be a health target as specified by the Ministry of Health. The value of a programme as perceived by GPs and practices is often reflected in the assistance it gives to the clinical outcomes on an individual patient basis.

When a programme is easy to use at the coalface and takes little time in the context of a consultation it will be utilised where it adds to the clinical effectiveness of the health intervention under the discussion at the time. The success of a programme is often measured, therefore, by the degree of acceptance and uptake by GPs and nurses, rather than by the health outcomes it is purported to improve. Does this reflect a good PHO?

Maybe the good PHO is the one that asks itself these questions and tries to answer them. One of the methods that has been used internationally – and has some merit – is the Balanced Scorecard.<sup>2</sup> In this scorecard there are four measures of performance:

- Stakeholder satisfaction – who are our stakeholders and how do these stakeholders at multiple levels see us? How does this influence their engagement and our effectiveness (and maybe therefore provider effectiveness)?
- Innovation/learning and high quality service provision – can we continue to improve and create value for multiple stakeholders?
- Internal business processes – what must we excel at in order to provide supportive and high quality services to our multiple stakeholders?
- Financial results – how do we look from the viewpoint of multiple stakeholders, considering their different agendas?

The value of the Balanced Scorecard has been explored in another article which was written about Health Maintenance Organisations and Preferred Provider Organisations back in the 1990s,<sup>3</sup> but it has obvious relevance to the PHOs of today (and perhaps the clinical network organisations of tomorrow).

A good PHO must question its value and make attempts to determine its value. The Balanced Scorecard is one way of giving structure to the question, and perhaps finding the answers we are all looking for.

## References

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3. Li LX and Benton WC, Performance Measure Criteria in Health Care Organisations. *European Journal of Operational Research* 1996;93:449-68.