

**Major Developments in Results-Based Financing (RBF)
in OECD Countries:**

Country Summaries and Mapping of RBF Programs

**New Zealand: Primary Health Organization (PHO)
Performance Program**

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Introduction

Primary health care is the cornerstone of the health care system in New Zealand and has a long history of being at the center of structural, and at times ideological, reforms. An unsuccessful attempt in the early-1990s to create a market-based system of competing purchasers and providers was followed, after the 1996 election, by the creation of a single national health purchaser. In 1999, the political pendulum swung again with a new Labour-led coalition government that distanced itself from market-based approaches and initiated a new radical reform of primary health care that moved toward greater control and financing by the government. General practitioners (GPs) have maintained their independence to operate as private practices and the right to charge patients fees for their services through these numerous fundamental reforms and swings of the political pendulum.

Throughout its evolution, primary health care in New Zealand has been funded by a partial fee-for-service payment from the government for consultations and pharmaceuticals, supplemented by substantial co-payments from patients. The high level of fees and copayments has been an ongoing political issue in New Zealand, as the social inequalities in GP access are exacerbated by the fee-for-service payment and high co-payments. Despite some targeting of government subsidies to higher need populations, inequalities in access have persisted, with poorer people and Māori often having higher health needs but using services at a lower rate (Barnett & Barnett, 2004). Fee-for-service not only has created barriers for some high-need patients, but also has provided little incentive for collaborative approaches by GPs or linkages with other parts of the health sector (Barnett & Barnett, 2004).

Under the umbrella of the New Zealand Health Strategy of 2000, the Primary Health Care Strategy introduced population-based approaches to address the growing inequalities (New Zealand Health Strategy, 2000). A set of 13 population health priorities and three priorities for reducing specific health inequalities were identified in the strategy, and reducing ethnic health disparities was an over-arching goal of the strategy. A new organizational structure, primary health organizations (PHOs), was established to focus on the priority health areas identified in the strategy and to address problems of access to services and a lack of coordination between providers.

A pay-for-performance program was introduced in 2006, the PHO Performance Management Programme to strengthen the role of PHOs and sharpen their focus on the population health and inequality priorities. This program is one piece of an overall quality framework and was designed by primary health care representatives, DHBs and the Ministry of Health to reinforce the combined health sector efforts to improve the health of enrolled populations and reduce inequalities in health outcomes through supporting clinical governance and rewarding quality improvement within PHOs.

Health Policy Context

What were the issues that the scheme was designed to address?

Until the 1990s, most GPs in New Zealand were sole private operators, completely independent from one another. The major health system reforms of the early 1990s, which were aimed at introducing a market model into the health sector through new contracting arrangements between providers and

newly formed government-funded purchasing agencies. In response, GPs organized themselves into Independent Practitioner Associations (IPAs), usually within defined geographic areas, to manage budgets for pharmaceuticals and diagnostic testing, and to pool savings to fund other local health initiatives. In 1999, over 80 percent of GPs were members of IPAs, which ranged in size from six to eight physician members to about 340 in a large association in Auckland, Pro Care Health (New Zealand Health System in Transition). These organizations were formed mainly to protect the business interests of GPs, and taking a more population-based approach to primary care was a secondary objective.

When the next major structural reform was introduced in the health sector in New Zealand in 1996, a single purchaser was established (the Health Funding Authority), and IPAs began to consolidate to gather some bargaining power against the new single purchaser. This was followed by the next restructuring in 1999 when the new Labor-led coalition came to power. The Health Funding Authority was abolished and replaced by 21 new District Health Boards to increase local involvement in the health system and improve the equity of financial allocations, and ultimately service utilization and outcomes (McAvoy & Coster, 2005). By that time it was widely perceived that the current model of primary care was not effectively addressing population health and equity and that the system was in need of investment and reform (Smith, 2009).

The 2000 New Zealand Health Strategy provided an overall framework for the health sector, with the aim of strengthening health services in those areas that would provide the greatest benefit for the population, focusing in particular on reducing inequalities in health. The approach was to focus and concentrate resources and efforts around these priorities, which were articulated in 13 population health objectives and three objectives to reduce specific inequalities (Table 1).

Table 1. Priorities in New Zealand’s 2000 Health Strategy

Population Health Priorities	
(1) Reduce smoking	(8) Reduce the incidence and impact of cardiovascular disease
(2) Improve nutrition	(9) Reduce the incidence and impact of diabetes
(3) Reduce obesity	(10) Improve oral health
(4) Increase level of physical activity	(11) Reduce violence in interpersonal relationships, families, schools and communities
(5) Reduce the rate of suicides and suicide attempts	(12) Improve the health status of people with severe mental illness
(6) Minimize harm caused by alcohol and illicit and other drug use to both individuals and the community	(13) Ensure access to appropriate child health care services including well child and family health care and immunization
(7) Reduce the incidence and impact of cancer	
Priorities to reduce inequalities	
(1) Ensure accessible and appropriate services for people from lower socioeconomic groups	(3) Ensure accessible and appropriate services for Pacific peoples
(2) Ensure accessible and appropriate services for Maori	

The new PHO organizational structure was introduced to focus GPs on the priorities identified in the strategy. PHOs are not-for-profit, non-governmental groups of individual GP practices that serve patients who enroll within a geographic area. GPs can join PHOs on a voluntary basis, but they must be part of a PHO to receive the government subsidy. The Primary Health Care Strategy also altered funding arrangements for primary health care to counteract the incentives of fee-for-service and encourage more population-based approaches. Under the Strategy, the main mechanism for delivering public funding to PHC changed from fee-for-service to capitation, with the intent of promoting a population-health approach and of promoting the role of non-GP health professionals. There is no requirement for PHOs to transmit the government subsidy to individual GPs by capitation, however, which makes it possible that some providers may still continue to receive public funding through the traditional fee-for-service payment (Coxson, Smith, & Cumming, 2009).

The community non-profit PHO model replaced the more profit-oriented IPA model to serve as a vehicle for increased government subsidies to reduce patient copayments (Gauld, 2008). The PHOs did not replace IPAs, and some of the larger PHOs rely on IPAs for management services (Gauld, 2008). The result has been a lack of clarity in the role of PHOs, and in particular how they relate to IPAs and DHBs, which has persisted since they were introduced in 2002 (Smith, 2009; Gauld, 2008). There are now 81 PHOs in New Zealand, covering over 95 percent of the population, and all of them involve communities in their governance processes (Ministry of Health of New Zealand, 2006).

The PHO Performance Management Programme, later renamed to PHO Performance Programme ('the Programme') was introduced in 2006 to sharpen the focus of PHOs on the priorities of the 2000 Health Strategy and manage unplanned expenditure growth (DHBNZ, 2005). The Programme, which includes a pay-for-performance component, aims to improve the health of populations and reduce inequalities through clinical governance and continuous quality improvement processes with PHOs and their contracted providers (PHO Performance Programme, 2010). The Programme is reinforced with financial incentives to record and pursue targets across the clinical, process and financial indicators, and also creating an information feedback loop to give PHOs access to their own performance data to use in their improvement processes.

Stakeholder Involvement

The Programme is administered by DHBNZ, which is a national organization representing the individual District Health Boards. DHBNZ unified the Programmes of the 21 District Health Boards into one national performance programme. The national programme is overseen by a governance group, including mandated members representing providers (from the General Practice Leaders Forum), PHOs, DHBs, DHBNZ, and the Ministry of Health (MOH) (PHO Performance Programme, 2010). The governance group was established in 2008 in response to criticisms about the lack of clinical leadership in the Programme. There is also a Programme Advisory Group, which provides expert advice about the content of the programme, and ensures clinical relevance and business sustainability (PHO Performance Programme, 2009). The initial Programme indicators were developed by DHBs/MOH as part of the Clinical Performance Indicator and Referred Services Management Projects.

Technical Design

How does the scheme work?

The Programme pays PHOs a performance incentive per enrolled person based on the percentage of targets the PHO meets for the ten performance indicators (see Table 2). To participate in the scheme, PHOs must fulfill eligibility criteria and receive DHB approval of its PHO Performance Plan (see Figure 1). DHBs provide start-up funding during the set up phase of a PHO entering the program. The “establishment payment” includes a fixed amount of \$20,000 per PHO, and a variable amount of 60 cents per enrolled person in the PHO (Ministry of Health of New Zealand).

The PHO Performance Programme also has a strong focus on the priority of reducing health disparities, which is achieved through three different pathways:

1. Measuring performance separately for high needs populations where appropriate;
2. Weighting payments towards progress against targets for the high needs populations for those indicators relating to an area of health disparity;
3. A weighting for high needs population in the pharmaceutical and laboratory expenditure targets (Ministry of Health of New Zealand).

Performance Domains and Indicators

The Programme includes a set of ten performance indicators covering the domains of service coverage, quality, and efficiency (Table 2). The indicators have evolved since the beginning of the Programme from more process/financial indicators to a greater emphasis on clinical indicators. Eleven indicators were used in Phase 1 (2006-2008), and these were updated and reduced to 10 indicators in Phase 2 (2008-present). Beginning in 2011 the efficiency indicators will be collected as “information only” indicators, because of concerns that they are inconsistent with the other indicators, where screening, management and treatment are desired outcomes (PHO Performance Programme, 2010).

Table 2. Current PHO Performance Programme Indicators

Indicator	General Population	High-Need Population
Coverage Domain		
Breast cancer screening coverage	No	Yes
Cervical cancer screening coverage	Yes	Yes
65+ years influenza vaccine coverage	Yes	Yes
Age appropriate vaccinations for 2-year-olds	Yes	Yes
Clinical Quality Domain		
Ischaemic cardiovascular disease detection	Yes	Yes
Cardiovascular disease risk assessment	Yes	Yes
Diabetes detection	Yes	Yes
Diabetes follow-up after detection	Yes	Yes
Efficiency Domain		
GP referred laboratory expenditure	Yes	No

Indicator	General Population	High-Need Population
GP referred pharmaceutical expenditure	Yes	No

Indicators were initially chosen based on data that were already available through claims data. For Phase 2, indicators were selected with a stronger focus on the agreed health priority areas for New Zealand, which meant the Programme had to invest in the infrastructure to generate new data directly from the GP practices rather than coming from claims data, which tended to under-report certain activities. For example, very little data were initially available on diabetes, hypertension, and smoking. Through the evolution of the program, these indicators were considered important, so the Programme made investments to ensure that the data were available. The DHBs and MOH shared the cost of the infrastructure for the new data. The Programme also invested heavily in consultations with provider groups, and automated data reporting that previously had been done manually. These steps ensured that new data for the Programme were not a burden to providers and helped gain their acceptance of the new indicators and reporting.

Some indicators are measured separately for “high-need populations,” which are rewarded at a higher rate. The PHO’s high needs population as defined by the sum of individual enrolled patients who are Maori (the indigenous population of New Zealand), Pacific Islanders or living in geographic areas with high relative socioeconomic deprivation. To strengthen the incentives to reduce health inequalities, the payments for performance are then weighted more heavily toward progress for the high needs populations. (Buetow, 2008).

Targets are set individually for PHOs using a national target-setting framework and taking into consideration their baseline performance (Figure 1). Indicator targets are agreed on an annual basis for the two six-month performance periods (i.e. 1 July to 31 December and 1 January to 30 June). The second six-month targets may be renegotiated between PHOs and DHBs on completion of the first six-month period if PHOs were unable to meet their targets. (PHO Performance Program).

Incentive Payments

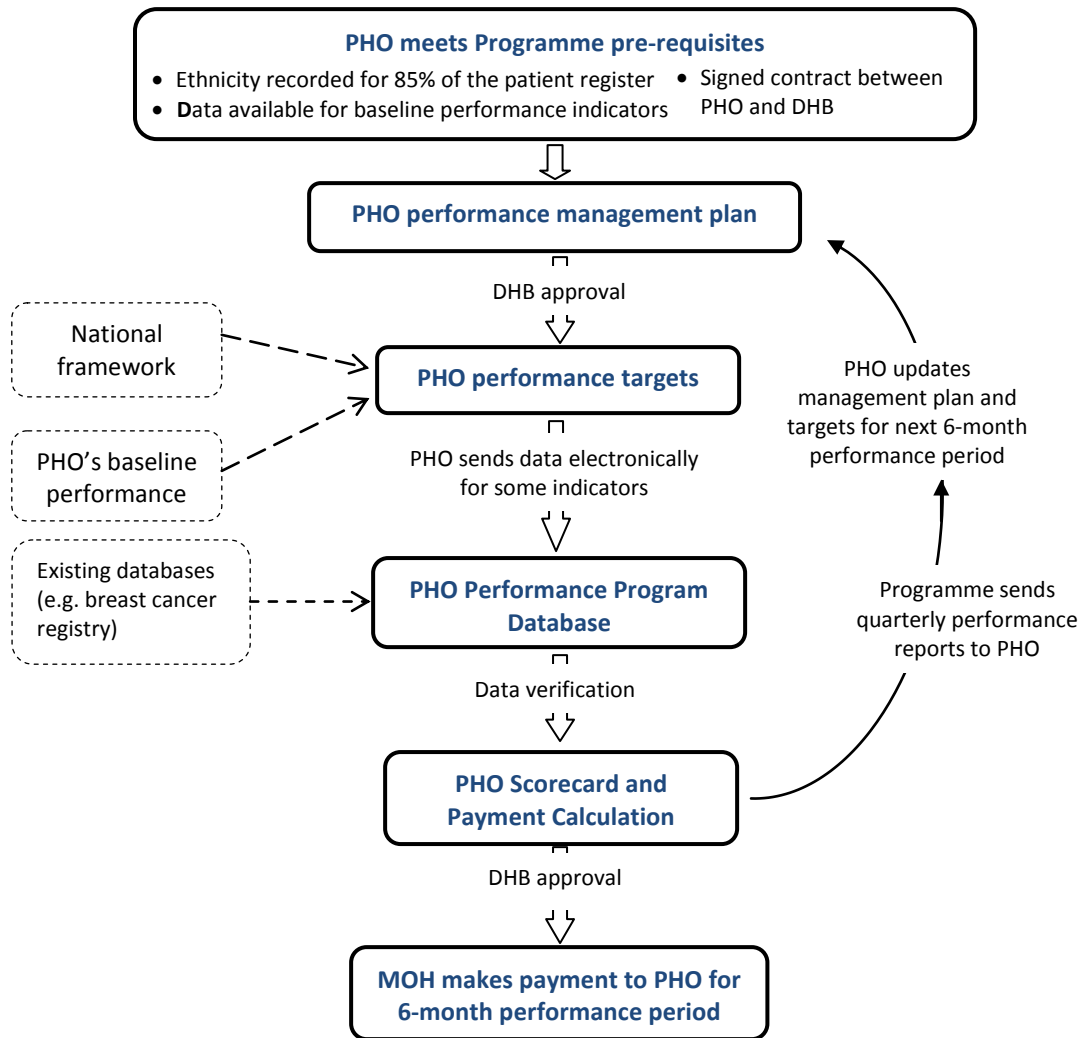
Flat-rate payments for the majority of indicators are made to PHOs for each six-month performance period based on the percentage attainment of each target. Performance payment amounts are based on the:

- population enrolled with PHO for the performance period;
- progress toward targets for each performance indicator;
- payment amount defined in the PHO Agreement per performance period per enrolled person;

The maximum available payment was initially set at NZ\$6 per enrolled member, if all targets were achieved. (Ministry of Health of New Zealand). The payment is not risk-adjusted. The bonus was increased to NZ \$9.27 in 2008 and will be reduced to NZ\$6.13 in 2011. Each target is assessed independently for a predetermined fraction of the total flat-rate payment, and “overachievement” against one target cannot be used to compensate for “underachievement” in another (Buetow, 2008).

DHBs have the flexibility to support local needs through additional funding to support more indicators or reinforce national indicators by applying additional funds to either all or particular indicators (providing this doesn't exacerbate existing health inequalities). (Ministry of Health of New Zealand).

Figure 1. Design of PHO Performance Programme



Data Sources and Flows

The Programme has a national database to enable the analysis and reporting of performance against targets. This database also calculates the performance payments for PHOs. Data for some indicators are sent electronically by PHOs using a standard form to the PHO Performance Programme team. Data for other indicators are retrieved by the Programme from existing databases (e.g. breast cancer screening register) (PHO Performance Management Programme)

A number of measures are taken to validate the data submitted by PHOs. Every quarter information from PHOs is run through logic algorithms, and there are variation markers to highlight unusual changes in indicators. The Programme dedicates significant time and resources to make sure the data are

accurate. If there are any discrepancies, PHOs have to justify unreasonable data, but no data are made available until they have been validated and agreement is reached with PHOs. If agreement is not reached, the Programme goes through a rigorous process to identify the reason for variation. For example flu vaccination rates come from claims data, and even when a claim is rejected, the service is counted. The claims data often underestimate actual coverage, however, because the providers may not submit claims for every vaccination.

Quarterly progress reports are provided to PHOs, DHBs and the Ministry. For each six-month performance period, DHBs review the PHO performance reports and scorecards generated by the PHO Programme team and approve the payment amounts. Once DHB consent is received, the Programme generates a payment summary confirming the amount to be paid to the PHO and forwards to the MOH to make the payment (PHO Performance Program).

Reach of the Scheme

Which providers participate and how many people are covered?

The Programme now covers all 82 PHOs, although participation is voluntary.¹ Uptake was rapid, beginning with 29 PHOs participating in 2006 (36%), 48 more PHOs entering by the following year (total of 95% of PHOs), and 100 percent coverage by 2008 (Ministry of Health of New Zealand). Nearly 100 percent of GPs and primary care nurses participate in the program through the network of PHOs, covering about 98 percent of the population. In terms of the importance of the financing, the total amount of performance payments is small in relation to total PHO incomes (Buetow, 2008) and makes up less than one percent of the government primary care budget.

Improvement Process

How is the program leveraged to achieve improvements in service delivery and outcomes?

The key feature of this pay-for-performance scheme is that it is a supporting component of the health sector's overall quality framework, and it is aligned with other initiatives to enable the primary care system to reduce inequalities and improve health outcomes of the New Zealand population (PHO Performance Programme, 2010). The financial incentives under the Programme are intended to better focus the activities of PHOs and provide some additional resources to enhance quality. The PHOs have discretion in how they use the bonus payments, but they require DHB approval, and there is an expectation that the PHOs use their bonus payments to deliver improved services in support of the objectives of the Primary Health Care Strategy, rather than to supplement the incomes of members or their practices (except perhaps to help recruit or retain practice staff) (Buetow, 2008).

There are no guidelines for distributing the bonus within the PHO, which has caused some ambiguity. For example, questions arose regarding whether it is better to distribute the bonus to high performers

¹ This information has recently changed with the Governments introduction of the Better, Sooner, More Convenient Policy and now there are 53 PHOs. Some of the original 82 PHOs have been merged, but they all are still participating in the Programme.

(reward) or low performers (investment) (Martin, Jenkins and Associates Limited, 2008). The ambiguity has led to tension in some cases, and not all PHOs have allocated performance payments due to these tensions. Practices often are involved, however, in decisions about how to use the incentive payment.

A case study of six PHOs found different approaches to allocating the bonus funds. One PHO did not distribute funds at all, one retained the funds at the PHO level to contract out for services such as education; and four PHOs shared the funds with GP practices. The distribution ranged from 15-60 percent of funds retained by PHO to compensate participation in Clinical Advisory Group, fund large initiatives, etc., and 40-85 percent distributed to GP practices. Three of the PHOs that shared the funding with GP practices distributed the funds on a capitation basis, with only one PHO distributing the funds based on achievement of targets (Martin, Jenkins and Associates Limited, 2008).

Some PHOs use the incentive payment for PHO-wide initiatives that benefit all practices, such as education or outreach initiatives. One PHO, for example, started a “mammogram bus” for the enrolled members of its GP practices. In some cases these global programs may have more impact on improvement than spreading the bonus across all providers, which would not be a significant amount for each individual practice.

The performance indicators and bonus payments are designed to be only a part of the PHO Performance Programme. Because of the low budget for the incentive, the Programme had to find other ways to drive change and performance improvement. The Programme works directly with providers to understand and address their individual performance issues. A large effort also has been made to feed information back to providers to use internally for performance improvement. Information is fed back to PHOs on the DHBNZ web site with security measures (Microsoft SharePoint). PHOs also receive timely monthly reports for four of the indicators (Flu, Cervical and Breast Screening and Immunisation) and a flat file of information on a quarterly basis with the information used to calculate their indicators, which is information they did not have available previously. The six-monthly DHB and PHO level reports also are made publicly available.

The Programme offers other services to support PHOs in their performance improvement processes. PHOs can receive individualized feedback reports on their own performance against the indicators as compared with benchmarks; nationally consistent education materials customized to their needs; and other services that may include the use of clinical facilitators. In spite of these efforts, however, it is not clear that the improvement process is moving beyond the PHO to the front-line GP practice level (Smith, 2009).

Results of the Scheme

Has the scheme had an impact on performance, and have there been any unintended consequences?

Program Monitoring and Evaluation

There has been no rigorous evaluation of the PHO Performance Programme. The efforts to monitor and evaluate the PHO Performance Programme have been largely ad hoc, relying on indicator analysis, small

sample non-rigorous surveys, case study approaches, and anecdotal evidence. For example, to help monitor early effects of the Program, the national DBNZ produced a questionnaire for the managers of the first cohort of 29 participating PHOs, with 16 responding. All respondents stated that as a result of the PHO performance management program their PHO had developed an increased focus on quality improvement, including clinical facilitation, data collection, data quality and feedback to member practitioners, and clinical governance groups. (Buetow, 2008)

An independent evaluation was completed in 2008 using a case study design. The key informant interviews were conducted with a purposive sample of 6 PHOs to include those of different sizes and serving different types of populations. The evaluation found that the Programme is perceived as useful by PHOs but more as a reinforcement of existing objectives and initiatives rather than an independent driver of improved quality.

Recently, the PHO Performance Programme began issuing an annual report that assesses the contribution of the Programme based on its objectives, and provides a trend analysis of the performance indicators (Performance Management Programme, 2009).

Performance Related to Specific Indicators

All ten performance indicators have shown some improvement since the Programme was introduced in 2006, but improvements are modest. For example, average breast cancer screening rates increased from about 55 to 66 percent for the total target population between 2006 and 2009, and cervical screening coverage increased from 66 percent to 73 percent. Rates of diabetes detection and follow-up increased from 46 to 55 percent for the total population. Rates of flu vaccination remained almost flat over the period, while greatest progress was achieved for childhood immunization, with rates increasing from under 60 percent to 87 percent (PHO Performance Programme, 2010).

Equity

There is some progress on the objective of reducing health disparities, as a number of indicators have improved relatively more for high-need populations than for the population as a whole. For example, the breast cancer screening rate for the high-needs population increased from 42 percent to 58 percent. This represents a 38 percent improvement, as opposed to only a 20 percent improvement for the general population over the same period. Other indicators, however, do not reflect a movement toward reducing health disparities. The rates of diabetes detection and follow-up increased from 50% to 60% for the high-needs population, which is the same 20 percent improvement in coverage that was observed for the general population (PHO Performance Programme, 2010). It is difficult to draw conclusions about the overall impact on equity and reducing health disparities.

Costs and Savings

The total budget for the PHO Performance Programme was NZ\$36.4 million in 2009, of which 93 percent is for the incentive payments (PHO Performance Programme, 2010). Of the total allocated for incentive payments, about 20 percent was not allocated to PHOs as a result of not fully achieving the targets.

As a share of total government primary care expenditure, the cost of the program is relatively small at less than one percent of expenditure. This does not take into account, however, the cost to providers of participating in the program and working toward and reporting on targets. For example, one large network of PHOs estimated that just under half of the funds it anticipated earning from the Programme would be needed to run the Programme (Buetow, 2008). For the most part, however, the PHOs are implementing the Programme largely with existing staff and structures, with senior PHO management overseeing the Programme (Martin, Jenkins and Associates Limited, 2008)

Provider Response

Initially the PHO Performance Programme was perceived as being imposed from the top and bureaucratic. This perception compounded a more general problem that the role of PHOs had never been fully clarified (or accepted) since the 2000 reforms (Smith, 2009). Some progress has been made, however, to garner the buy-in of GPs through a more participatory governance structure, investments by the Programme to support better data systems, and a process-oriented approach to interpreting and using performance information beyond simply calculating bonus payments. Other factors that are considered to be important for gradually increasing the buy-in of providers is that the indicators have evolved to take on a more clinical focus and are based on clinical evidence, and that the Programme clearly is designed to be aligned with and supportive of the 2000 Health Strategy, which is widely accepted as definitive for setting the priorities and guiding principles for the development of the health sector (Gauld, 2008)

Overall Conclusions and Lessons Learned

Has the scheme had enough of an impact on performance improvement to justify its cost?

In general, it is perceived that the PHO Performance Programme has made a positive contribution to furthering the objectives of the 2000 Health Strategy, even if the incentives themselves are too diluted to be the real motivator of change. The Programme is perceived as aligning with and reinforcing overarching objectives of the strategy, which were agreed to by all of the stakeholders. The Programme is considered to have had value-added by focusing attention on priority areas and raising awareness. The Programme also has been regarded as successful at taking a comprehensive approach—providing resources, tools, and processes in addition to incentives to change clinical practice (Martin, Jenkins and Associates Limited, 2008). The clinically credible indicators and collaborative governance have been key to this success.

As in the case of the U.K. QOF, an important positive spill-over effect of the P4P program is improved collection and use of data for quality improvement purposes. There also is an overall improvement in clinical governance of the primary care sector. Establishing clinical governance structures and a process to engage professional members and achieve improvements is a criterion for PHO participation in the program (Buetow, 2008). Furthermore, the program is overseen by a tripartite governance group consisting of representatives of providers, PHOs and DHBs. Overall governance of the PHC sector has become more participatory, as multiple stakeholders have remained actively involved in designing and

shaping the Programme, and PHOs and providers have made ongoing investment in the Programme's governance structure (PHO Performance Programme, 2009).

Although the PHO Performance Programme is playing an important role in reinforcing broader quality initiatives, the incentive itself is extremely limited in its potential to drive changes in clinical practice, improvements in provider performance, and better outcomes. The main issues are:

- (1) **The size of the incentive is small.** There are no good estimates of what percentage of PHO budgets or GP practice income are contributed by the incentive, but total incentive payments make up less than one percent of government primary care expenditures. This is a particularly small incentive in comparison to the U.K. Quality and Outcomes Framework (QOF) scheme, which is often used as a comparison in discussions of the PHO Performance Programme. The QOF can represent up to 30 percent of the annual income of GP practices in the U.K. (Campbell et al. 2007). In fact the assessments of the program that have been done attribute any achievements to the compounding effect of the incentive rather than the incentive itself.
- (2) **There is a disconnect between program management, payment of the incentive, and clinical providers.** The main criticisms of the 2000 Health Strategy often center on the need for more change at the practice level to bring about better care coordination (Smith, 2009). The structure of the program and the ambiguous relationship between PHOs and GP practices makes it difficult for comprehensive performance improvement initiatives to reach day-to-day clinical practice. This is a more general problem of the role of PHOs in the primary care system. Furthermore, the funds are not transparently distributed or reinvested, which can limit the motivational and recognition aspects of the program.

Conclusion: The investment in the PHO Performance Programme has been small, however, and there have been no reports of adverse consequences of the Programme or gaming by PHOs. It may be the case that improvements in data use, clinical governance, and population-based initiatives that have been motivated by the program may be yielding sufficient system-wide benefits to make the investment in the PHO Performance Programme effective. This conclusion could only be drawn, however, by a rigorous evaluation of the program, or at least more systematic monitoring and analytical assessments.

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