PHO Alliance

He huinga ratonga hauora

Annual **Report**

For the year ending 30 June 2011

The hub for the development, exchange and promotion of policies and strategies which advance the objectives of the Primary Health Care Strategy through its member Primary Health Organisations.

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CHAIRMAN'S REPORT

Knowing that Michelle has prepared a comprehensive report on the activities of the PHO Alliance in the past year I want to take this opportunity to comment on our role in the primary health care sector. I will use this last occasion as your chairman to look back five years to our formation, and look confidently to the future.

The PHO Alliance had its genesis at an early morning meeting of PHO chairs hosted by IPAC at the IPAC conference in Christchurch in 2005. About twenty of us sat around and exchanged thoughts about our common experiences as we worked to set up new PHOs or reshape IPA organisations in response to the Primary Health Care Strategy launched in 2001. We all felt there could be value in a peer group and continued to meet occasionally until in June 2006 an interim committee chaired by Dr Richard Tyler convened the inaugural meeting of the PHO Alliance Incorporated.

We adopted a mission statement (as was the fashion) which is still valid today. ***"The PHO Alliance will be the hub for the development, exchange and promotion of policies and strategies which advance the objectives of the Primary Health Care Strategy through its member Primary Health Organisations".*** We were exceedingly fortunate in gaining the services of Michelle Thompson as Executive Officer, and we commenced to build a loose but effective association of PHOs ranging widely in size and located from Invercargill to Auckland. Initially there were thirty member PHOs, rising to a peak of thirty nine in 2009. While our total enrolled population has continued to rise – now 2,820,000 - amalgamations and reconfigurations have reduced the membership to nineteen this year.

How have we fulfilled this self-defined role? I do not think we have collectively made a significant impact on primary health care policies. The reins of health policy have been firmly held by the various Governments and their Ministry. There are few if any forums in which health policy is discussed productively. We have been able to modify policy implementation on occasion, for example achieving a reduction in the number of PHOs voluntarily rather than by financial strangulation. We have been able to improve Ministry policy initiatives, for example in prescribing minimum governance standards through consultation rather than by fiat. We have not been successful in achieving greater targeting of public funding in primary health care although this is an objective widely supported. The only significant move in this direction, the introduction of the Very Low Cost Access scheme occurred without any consultation, and is less effective as a consequence.

We have been more successful in promoting and exchanging implementation strategies within our membership and across the wider primary health sector. I observe that by exchanging our varied experience of relationships with DHBs these partnerships have significantly improved. I recall a time when some DHBs denied PHOs any access to the District Annual Plan processes and now I know that many PHOs play a critically important role in planning and implementing the primary health care portion of their DHB's DAP. A meeting of PHO, DHB and Ministry leaders I attended only last month shows me that there is still room for improvement in many of these relationships.

The role of PHO Alliance in managing a significant investment in the governance processes of PHOs, not only in our own organisation but in the other PHO groupings, was spearheaded by Michelle and contributed to by many of our PHO board members. PHOs have shown themselves almost without exception to be soundly governed and managed organisations. We have developed various mechanisms and relationships which underpin our ability to exchange

knowledge. I am sure many of our members reach for a phone number or email address on our membership list when they seek an answer to some local problem, or want to share a concern with colleagues. This free flow of information and experience is invaluable in a sector where, while operating in separation, we face common circumstances.

The intense pressure of developing Better Sooner More Convenient (BSMC) business cases, of reconfiguring PHOs and realising the dream of whanua ora, has seen some reduction in both the capacity and the opportunity for this sharing. We have not been able to continue to hold regular meetings for member Chief Executives, and significant progress in developing collaborative relationships with other PHO groupings has slowed almost to a halt. There has been so much to do, and so much pressure to continue to operate despite falling management funding, that we risk becoming isolated in the way we were before 2005. I see the same thing happening in DHB land. It is of concern that a colleague who attended a recent meeting of DHB chairs and chief executives to discuss expansion of the BSMC strategies noted a dearth of understanding of what the primary health care sector is doing, and more importantly what it could do in future.

It is worthwhile asking ourselves if we add value. How have PHOs added value to the Primary Health Care Strategy, and how can they add value to the BSMC strategy? The clinical leadership and clinical governance required for successful implementation of both strategies is readily available from existing clinical networks such as NZMA, GPNZ, NZRGPN and others. The managerial and administrative input required can be gained in any number of ways from the excellent health managers deployed in MSOs, DHBs, the previous RHAs and HFA – ever noticed how many of the people have been recycled through all these organisations? There is another component that neither of these groups can provide, a component that I believe is essential if we are to achieve our goals of a healthy NZ population and an affordable health care system. That component is an involved community. Not by consumers with their legitimate individual and collective private interests but by the community with its political and public interest.

I believe that health is too important to be left just to doctors and nurses, just to clinicians. Actually I have borrowed that quote – the original was that ‘education is too important to be left to teachers’. Both sayings encapsulate the same idea. Health and education are community as well as private responsibilities. When we say it takes a village to raise a child, we are talking about the whole child, and referring to the physical, emotional, and intellectual development of that child.

We talk about the need to break down the boundaries between primary and secondary health care, between what is done in the hospital and what is done in the clinic, practice or integrated family health centre. There is another boundary to be overcome. That is the boundary between the health care provided by clinicians when we are unwell, and the actions and influences which are provided by family and whanau, school, iwi, church or social group which help us keep well. I believe that because of the unique combination of clinician and community leadership at their core, PHOs can and have added value in breaking down those barriers. In the future, as the costs of clinical care rise faster than our ability to create wealth, we will need more and more of that community activity to reduce our exclusive reliance on clinical health care.

For that reason I wish more power to the arm of the PHO Alliance, to all PHOs, and to all those community workers and leaders who can be recruited to the service of our health, and the health of our children and grandchildren.

I have been honoured to be your chairman. I have been privileged to meet and work with many skilled and dedicated people both within the Alliance and in other health forums to which I have been introduced. I must particularly mention my sincere appreciation of the partnership I have

enjoyed with the other members of the executive committee, and with Michelle. We have been extraordinarily well served by our Executive Officer again this year.

The past five years have been years of growth and personal satisfaction for me, and for that opportunity I thank you all and wish you all well in your valuable work.

Hamish Kynoch
Chairman

EXECUTIVE OFFICER'S REPORT

The door has opened on our sixth year of operation and as I sit down to write this column my overwhelming impression of the year just passed has been one of frenzy.

Consolidations have continued in earnest, nationally there are now 35 PHOs across the country which is down from a peak of 82 in 2007. In terms of the PHO Alliance, current membership stands at 19 organisations which is 20 less than our peak of 39 in 2009. Despite these changes the combined enrolled population of our organisation is 2.8 million, which is the highest it's ever been.

During the past 12 months

- We have welcomed: Eastern Bay Primary Health Alliance; Health Hawke's Bay; Cosine Primary Care Network; Southern PHO and ProCare Networks into the fold.

- And we have farewelled: Karori PHO; Ropata PHO; Tamaiti Whangai PHO; Tu Meke First Choice PHO; ProCare Network Auckland; ProCare Network Manukau; Mangere Community Health Trust; Valley PHO; Total Healthcare Otara and Hawke's Bay PHO.

Our thanks and appreciation to all the departing members, especially to their chairs and chief executives for all that they have contributed. It is reassuring, as Hamish has noted, that many of our governance and management experts have been recycled into the newly formed organisations.

During the year, I have been struck by how busy everyone is "*BSMC-ing*" and how little time this has left for senior management to work "on their business" rather than working "in their business". My anecdotal evidence for this claim - working across several organisations - is:

- The state of my garden - I often do my best thinking while working in the garden but this year the garden's a mess. This tells me the work life balance is out of skew, I have failed to protect quality thinking time and come summer, the roses will be sub-standard.
- The late night email activity – it is not unusual to send an email out at 10pm on Saturday evening in preparation for a response on Monday morning, when half a dozen responses come back within minutes.

Danny Wu made the comment when he spoke to us back in December last year that change was being introduced in such a fluid environment it was leaving little time to think about the context in which the Ministry was operating. At last year's Annual Meeting Dr Murray Horn said that PHOs need to become more "bank-like" in their behavior. He said contracts will come to those that have the necessary revenue streams and can demonstrate a clear ability to manage risk.

While these may be admirable business ideals, trying to progress them while the foundations are continually moving (literally for our Canterbury colleagues unfortunately) and money is becoming ever tighter, some serious HR challenges are starting to emerge. Top of the list is the workload pressures now facing our Chief Executives and Chairs. Due to the bigger-is-better mantra, increased workloads are being spread across fewer individuals and at the national level this has meant fewer people are available for participation in national working parties. It is also becoming more difficult to protect the voice of smaller communities, particularly rural

communities, within these larger conglomerates. As the Minister said back in June, community engagement is not his bag – it's ours. This needs to come back on our agenda.

All in all, ever increasing expectations are being placed upon our senior leaders in primary health care and when coupled with prolonged periods of expansion and/or uncertainty extra care is needed to ensure they have access to good quality professional development opportunities and collegial support. Now is not the time to cut back on these budget items. Those based in Canterbury will need an extra special level of support if they are to survive the long-haul.

Speaking of the long-haul, how does one find the appropriate words to farewell Hamish? I will try a few:

Hamish, you have been the most supportive and helpful boss one could want. You have an amazing ability to join the dots and you have remained true to the principles of good governance in all that you do. You have been a firm proponent of the importance of community involvement in improving health outcomes. It has been an honour and privilege to work alongside you and I wish you all the very best for the future. It is good to know you are staying on the Executive in a co-opted capacity for a while longer and that you are willing to hold the PSAAP Facilitator role for a further six months. So it's not quite goodbye yet.

To the new chairperson – as yet unknown - you undoubtedly have big shoes to fill but I am confident, given the high level of expertise amongst our membership, you will do so admirably and I am looking forward to working alongside you over the coming months.

With every best wish to all

Michelle Thompson
Executive Officer
michelle@ceo2.co.nz

PRIORITIES AND DIRECTIONS ACHIEVED 2010-2011

Building relationships, information sharing and contributing to primary care policy discussions continue to be the main strategic focus of the PHO Alliance. The four high level strategic objectives determined by the Executive Committee for the 2010-2011 year were:

1. To merge with PHO New Zealand.
2. To be actively involved in high level primary health care policy discussions.
3. To enhance connections with DHBs.
4. To enhance connections with the Ministry of Health.

The following table reports progress and activities against these objectives.

Priorities	Status	Comments
To merge with PHO New Zealand	On-going	Regular contact was maintained with PHO New Zealand executives throughout the year. In November 2010 a survey was conducted with members to ascertain the level of support for a formal merge between the two organisations. The results showed strong support for a merge and at the December 2010 General Meeting a formal motion to this effect was recorded. It was thought that the central purpose of the new organisation would be to provide: advocacy and representation; sharing of information and experiences; being a conduit between PHOs and the Ministry and the NHB and supporting members to implement the Primary Health Care Strategy (PHCS). A name change and further co-option to the Executive Committee was also supported in order to reflect the new and expanded organisation. PHO New Zealand members considered this offer at their Annual Meeting in December and decided that - for the time being - they would prefer to continue as an autonomous organisation but would continue to welcome close cooperation with the PHO Alliance. Apart from strength in numbers, particularly in rapidly changing times, the other driving factor behind merging with PHO New Zealand was the desire to secure economies of scale. To this end: • A constitutional change was approved to allow members other than PHOs to join the Alliance. Organisations can now be considered for membership if they hold a primary health care contract and support the charitable objects of the Society. • A four tiered levy structure was implemented for the 2011-2012 financial year to assist with the financial viability of the organisation. • Members were given the ability to join for six months and to pay their levies in installments to help navigate through consolidations and general uncertainty.

To be actively involved in high level primary care policy discussions	On-going	This objective has been the most difficult one to achieve as it demands greater capacity that we currently have. We have endeavoured to participate in as many high level discussions as possible and to interact with key people in the sector. **Government** • Hon Tony Ryall, Minister of Health, addressed members at the June 2011 General Meeting on: *The Budget implications for primary health care and PHOs.* Central messages from the Minister were: he no longer agreed with the OECD's comments of several years ago that PHOs are an unnecessary bureaucratic layer. Instead he urged PHOs to contribute to BSMC outcomes by: embracing change based upon scale, integration and services closer to home; engendering stronger clinical engagement across the community including hospital and pharmacy; encouraging multi-disciplinary work and improving access, in particular, after hours. He also said PHOs need to increase their productivity in the face of tight financial times and to give strong support to the health targets by lifting their poor performers. **Ministry (see 4th strategy below)** **National Health Board (NHB)** • Dr Murray Horn, Chair NHB, addressed the September 2010 Annual Meeting on the topic: *How primary health should be configured to deliver best value to the NZ health system*. His key message was: now is a critical time for PHOs, they need to step up by helping to reduce pressure on the secondary system and to live up to the vision espoused in the PHCS. • Chai Chuah, National Director NHB, is guest speaker at the September 2011 Annual Meeting and will be speaking on: *The implications for PHC now that it's the responsibility of the NHB*. **Te Puni Kokiri** • Rob Cooper, Chairman Whanau Ora Goverance Group and Geoff Short, deputy Chair Whanau Ora Governance Group and Head of Strategic Policy, Te Puni Kokiri, presented to members at the December 2010 General Meeting on: *Whanau Ora policy development and linkages with mainstream*. Their key messages were: Whanau Ora is a top priority. It is a government mandated authorising environment and it will take a long time to get right. They want the Whanau Ora model integrated into the new health system and this will inevitably mean more interaction with PHOs. In the meantime they encouraged PHOs to start developing relationships with the lead Whanua Ora provider in their region.

		National Sector Groups The PHO Alliance is formally represented on the following National Sector Working Groups: • PHO Service Agreement Amendment Protocol Group (PSAAP). • PHO Performance Programme Governance Group. • National Pandemic Planning Group. **National PHO Collective** Collective members have tried to maintain contact throughout the year but a face to face meeting was thwarted due to EoI/BSMC and Whanau Ora pressures. Invites to our general meetings have been extended to key individuals throughout the year and we have continued to share important documents. PSAAP negotiations have provided further opportunity to engage with the representatives of the other national organisations. **General Practice Organisations** Good working relationships are enjoyed with general practice organisations: • The PHO Alliance Chairman has attended GPNZ Council meetings on a regular basis. • PHO Alliance and GPNZ are members of the joint PSAAP negotiating team and as such meet frequently throughout the year in person and via tele-conferences. • An informal discussion initiated by the GPNZ Chair regarding closer collaboration between PHO Alliance and GPNZ has been considered by the Executive Committee. • Involvement of GPNZ and NZMA in the development of a Back to Back Contract template has not continued due to those organisations' priorities. **Health academics** • Geoff Simmons, Morgan Foundation, presented to the December 2010 General Meeting on: *How primary health should be reconfigured to give best value to the NZ health system*. Geoff's key message is that our current health spend is unsustainable for a country of our size and GDP output and needs to be curtailed as a priority through: stemming the tide of increasing demand (increased investment in primary care and preventative treatments will only work if access to secondary care is restricted); rationing services (by an independent board made up of health sector professionals) and improving our delivery structures (facilitation not competition).
To enhance connections with DHBs		This strategy has proven difficult with the demise of DHBNZ. However, PSAAP negotiations throughout the year have provided a good platform for engaging with DHB representatives.

To enhance connections with Ministry of Health		Regular communications with, and presentations to members at General Meetings by, senior Ministry staff: • Danny Wu (National Programme Manager Primary Health Care Implementation) spoke at the December 2010 General Meeting on: *The intended policy direction for 2011, the concept of second generation PHOs and relevance for PHOs outside the business cases*. Key points were: pace of change has been significant over past 12 months; Ministry has been trying to introduce change in a very fluid environment making it difficult to think about the context in which they are operating. Intended future direction is to continue down the BSMC pathway without having to put PHOs through another business case round. The aim is to give operational flexibility at the local level which will involve: shifting services from hospitals; developing IFHCs and reviewing DHB appointments. • PSAAP negotiations have also provided a useful way to engage with Ministry representatives.
Information sharing	On going	**Website** Members share information on a regular basis via email. The website is advancing our exchange and promotion function and is becoming a valuable repository of primary health care resources: An overview of traffic statistics in the last year are: **Public website** www.phoalliance.org.nz • 1,018 unique visitors made 1,304 visits, averaging 3.5 pages per visit and stayed approximately 2 minutes per visit. • Most popular pages were Information (of which the BSMC and PSAAP pages were the most popular) and About Us. • 14% of visitors came to us directly, 81% by search engines and 5% by referring sites. • Visitors came from 31 different countries, the top five of which were: NZ (1153); USA (71); Australia (20); India (11) and UK (11). **Members only site** www.phoalliance.org.nz/members/ • 31 unique visitors made 83 visits, averaging 4 pages per visit and stayed approximately 4 minutes per visit. • Most popular pages/documents were General Meetings, Clearing House (of which the Governance Remuneration Survey was the most popular) and the general practice consolidation & IFHC services available through Pricewaterhousecoopers. **Clearing House/Surveys** The main survey conducted during the year was the Governance Remuneration Survey of which the key findings were: • The average remuneration for PHO chairs is $18,000 pa, mode $24,000, range $1,800 to $50,000. • Average number of board members is 9, mode 10,

		range 7-16. • Average length of board meetings is 3 hours, mode 4, range 1-4 hours. • Average number of board meetings per annum is 10, mode 11, range 6-12.

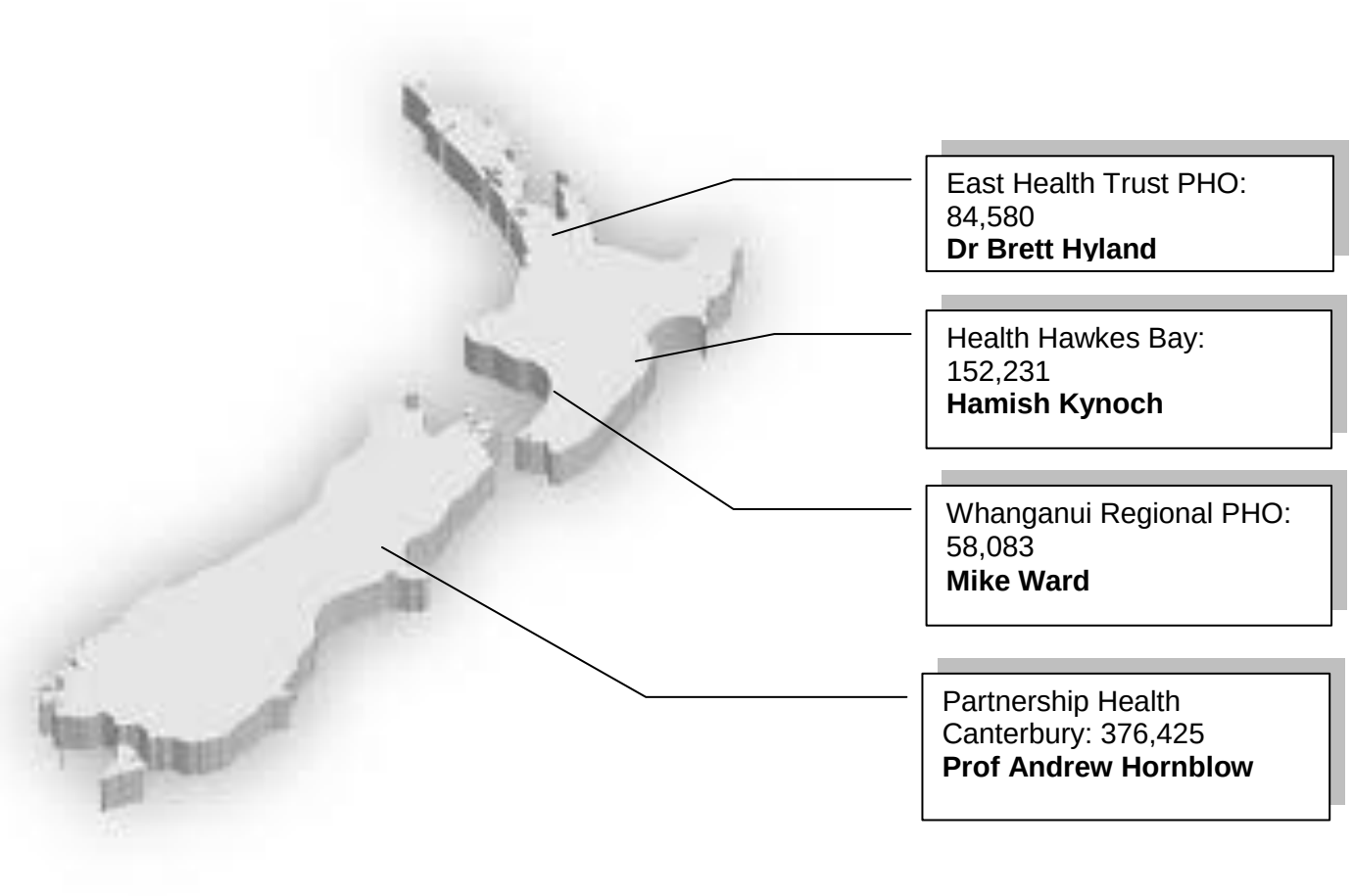
PROPOSED PRIORITIES AND DIRECTIONS 2011-2012

Work on determining the strategic focus and high level activities for the next 12 months will be undertaken by the new executive committee following the 2011 Annual Meeting. Positioning members to cope with the actual and potential changes in the national scene is likely to be the central thrust of the new strategic direction.

EXECUTIVE COMMITTEE

Clause 9.1 of the Constitution allows for a core executive committee of four: a chairperson and three other members. The executive committee also has the power to co-opt members from time to time to ensure adequate representation of rural and urban interests, geographic location, and the size of members PHOs, and to enhance its capacity to respond to issues as they arise.

Brief biographies of the 2010-2011 Executive Committee are included over the page. The map below shows respective geographical locations and enrolled populations.



HAMISH KYNOCH – CHAIRPERSON (ELECTED) • Immediate past chairman of Hawke's Bay PHO. • Background in NGO and community governance, and local government • A farmer with a non-clinical community perspective. Portfolio of responsibility: Public Relations	**DR BRETT HYLAND – EXECUTIVE (ELECTED)** • Chair of East Health Trust PHO • General Practitioner • Director of East Health Services Limited (MSO) • Director East Care Limited (A&M) • Honorary Clinical Senior Lecturer • Member Institute of Directors • Broad knowledge of the primary health sector from provider and management perspective. Portfolio of responsibility: Clinical
MIKE WARD- EXECUTIVE (ELECTED) • Chair of Whanganui Regional PHO • Director Gonville Health • Manager Whanganui Community Living Trust • Particular areas of interest are the disability sector and the community not-for-profit sector.	**ANDREW HORNBLOW- EXECUTIVE (ELECTED)** • Chair of Partnership Health Canterbury, • Former chair of various crown agencies and national and regional health sector organizations • Emeritus Professor University of Otago, • Adjunct Professor University of Canterbury.

LIST OF MEMBERS @ August 2011

Member PHOs	Date Joined	Enrolled Pop @ Apr-11	Chair	DHB	PHO Street Address
Compass Primary HealthCare Network	1-Jul-10	249,128	Larry Jordan	Capital & Coast	Level 7, Freemason House, 195-201 Willis St, Welllington 6011
Christchurch PHO	22-Aug-06	31,500	Angus Chambers	Canterbury	Level 2, 160 Bealy Ave, St Albans, Christchurch
Eastern Bay Primary Health Alliance	1-Jul-11	45,529	Bryan Gould	Bay of Plenty	29-31 Richardson St, Whakatane, 3120
East Health Trust PHO	30-Jun-06	84,580	Brett Hyland/Denis Lee	Counties Manukau	Building B, 260 Botany Road, P O Box 38-248, Howick, Auckland
Harbour Health PHO	16-Oct-07	150,758	Kate Baddock	Waitemata	Building B, 42 Tawa Drive, Albany, North Harbour 0632
Health Hawkes Bay	1-Apr-11	152,231	John Newland	Hawkes Bay	Staples Rodway Building, Cnr Lyndon Road and Hastings St, Hastings
Health Rotorua PHO	25-Jul-06	71,746	Russell Burton	Lakes	Unit 2, 55 Marguerita St, Rotorua
Cosine Primary Care Network	1-Jan-11	33,298	Murray Gough	Capital & Coast	11 Parkvale Road, Karori, Wellington
Kimi Hauora Wairau Marlborough PHO	7-Aug-06	41,967	Joe Puketapu	Nelson Marlborough	Level 4, Cavalier House, Cnr Market St/Alfred St, Blenheim
Central PHO	1-Jul-10	152,228	Colin McJannett	MidCentral	575 Main St, Palmerston North
Nelson Bays PHO	29-Sep-06	93,000	John Hunter	Nelson Marlborough	20 New Street, Nelson
Partnership Health Canterbury PHO	15-Aug-06	376,425	Andrew Hornblow	Canterbury	56 Shirley Road, Christchurch
ProCare Networks	1-Jan-11	698,167	Harley Aish	Auckland/Counties Manukau	Level 2, 110 Stanley St, Grafton, Auckland
Rural Canterbury PHO	10-Aug-06	84,993	Allan Marriott	Canterbury	2/567 Wairakei Road, Christchurch, 8053
Southern PHO	15-Feb-11	281,896	Conway Powell	Southern	1 Bond St, Dunedin 9054
Wairarapa Community PHO Trust	30-Jun-08	39,789	Elaine Brazendale	Wairarapa	Level 1, 49-52 Lincoln Road, Masterton
Western Bay of Plenty PHO	25-Jul-06	143,706	John Gemming & Tatai Allen	Bay of Plenty	126, Eleventh Avenue, Tauranga
West Coast PHO	27-Feb-09	31,027	John Ayling	West Coast	Level One, 163 Mackay St, Greymouth
Whanganui Regional PHO	10-Aug-06	58,083	Mike Ward	Whanganui	Level 1, 76 Guyton St, Wanganui
TOTAL -PHO ALLIANCE		**2,820,051**			

FINANCIAL STATEMENTS

Summary of financial performance 1 July 2010 – 30 June 2011

The PHO Alliance's income receipts for the twelve months ending 30 June 2011 were $130,980 and total expenditure was $150,502 resulting in a net operating deficit of $19,522 (against a budgeted year-end deficit position of -$31,990).

The main expenditure items were management and financial services (70%), executive fees and expenses (13%) and PSAAP expenses (8%).

Total equity as at the end of the fifth year of operation is $66,990 of which $14,144 is ring-fenced for governance development activities.

Summary of main differences between Actual Income & Expenditure 2010 and 2011

Total income in 2011 was $64,150 less than in 2010 for the following reasons:

- $45,000 less in membership levies due to consolidations.
- $2,000 less earned on terms deposits due to dwindling cash reserves.
- $13,356 less contract income due to the completion of the DHBNZ Governance Development contract. $4,000 was earned from the sale of the back to back template.
- No fees from national sector representation i.e. Primary Health Care Advisory Committee.
- No sundry income i.e. contribution from members of the National PHO Collective for work done on their behalf on the Governance Development Programme.

Total expenditure in 2011 was $40,799 less than in 2010 for the following reasons:

- A concerted effort to reduce expenditure in line with reduced income.
- No governance development payments to members due to the conclusion of the Governance Development Programme in the previous year.
- PSAAP activity and executive fees & expenditure both notably less than anticipated.

PHO ALLIANCE
INCORPORATED

FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2011

DIRECTORY

PHO ALLIANCE Inc
STATEMENT OF FINANCIAL PERFORMANCE
FOR THE YEAR ENDED 30 JUNE 2011

	2011 $	2010 $
Income		
Membership Fees	124,000	168,986
Contract Income	4,000	17,356
Other Income	2,980	8,788
Total Income	**130,980**	**195,130**
Expenses		
Back-to-Back Contract	8,112	5,334
Bank Charges	206	222
Catering	1,161	2,043
Contract Expenses - PHO Payments	0	17,356
Contract Expenses - Project Expenses	0	510
Depreciation	1,166	2,240
Executive Fees & Expenses	18,960	22,936
Management & Financial Services	106,100	106,100
Meeting Expenses	134	1,001
National Sector Representation	0	1,506
National PHO Collective	0	2,075
PSAAP Expenses	12,171	23,749
Sundry Expenses	123	2,236
Telephone	1,019	1,587
Venue Hire	1,350	1,800
WebSite	0	606
Total Expenses	**150,502**	**191,301**
Net Surplus/(Deficit)	**(19,522)**	**3,829**

These accounts are to be read in conjunction with the attached Notes to the Financial Statements

PHO ALLIANCE Inc
STATEMENT OF MOVEMENTS IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2011

	2011 $	2010 $
Opening Balance as at 1 July	**86,512**	**82,683**
plus (Deficit)/ Surplus for the year	(19,522)	3,829
Total Recognised Revenues and Expenses for the Year	(19,522)	3,829
Closing Balance as at 30 June	**66,990**	**86,512**

These accounts are to be read in conjunction with the attached Notes to the Financial Statements

PHO ALLIANCE Inc
STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2011

	2011	2010
Assets	**$**	**$**
Current Assets		
Bank Accounts	76,845	97,138
Accounts Receivable	3,047	450
GST Receivable	4,684	5,143
Total Current Assets	**84,576**	**102,731**
Fixed Assets		
Web Site	**1,261**	**2,426**
Total Assets	**85,837**	**105,157**
Liabilities		
Current Liabilities		
Accounts Payable	4,703	4,501
Governance Development Pre-payments	14,144	14,144
Total Current Liabilities	**18,847**	**18,645**
Net Assets	**66,990**	**86,512**
Equity		
Retained Earnings	66,990	86,512
Total Equity	**66,990**	**86,512**

Signed by:

Chairperson

Executive Officer

Dated: 16 August 2011

These accounts are to be read in conjunction with the attached Notes to the Financial Statements

PHO ALLIANCE Inc
NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2011

STATEMENT OF ACCOUNTING POLICIES

1. Reporting Entity

PHO Alliance Incorporated is a body that represents and promotes the interests of its members. The PHO Alliance does this through advising and consulting with key stakeholders in the sector, representing common positions on issues of substance to key stakeholders, and facilitating the performance of member organisations through information and resource sharing.

The Alliance's members are organisations responsible for the provision of general practice services and other primary health care services, to just over 2.8 million New Zealanders.

The financial statements have been prepared in accordance with generally accepted accounting practice as required by the Institute of Chartered Accountants of New Zealand.

2. General Accounting Policies

General accounting policies have been adopted in the preparation of these financial statements.

a) The measurement base adopted is that of historical cost and reliance is placed on the fact that the PHO Alliance is a going concern.

b) The matching of revenue earned and expenses incurred is applied using accrual accounting concepts.

c) The PHO Alliance Inc. is registered as a charitable entity under the Charities Act 2005. It is therefore exempt from Income Tax.

3. Differential reporting

The PHO Alliance qualifies for differential reporting as it is not publicly accountable and it qualifies as being a small entity as per the framework for differential reporting. The PHO Alliance has taken advantage of all available differential reporting exemptions.

4. Goods and Services Tax

The financial statements have been prepared stating all income and expenditure items exclusive of GST.

5. Fixed Assets

The PHO Alliance has developed a web site which is depreciated at 48% DV.

6. Financial Operations

This is the 5th financial year the PHO Alliance has been operating.

7. Auditors

For the year ending 30 June 2011, the PHO Alliance Inc has not appointed auditors.