PHO Alliance

He huinga ratonga hauora

Annual **Report**

For the year ending 30 June 2012

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.

CONTENTS

CHAIRMAN'S REPORT

As a PHO Chair since 2003, and a member of the PHO Alliance since 2006, I attempt to regularly review the reasons for my involvement as a non-clinician in primary health governance. Goals which captured my imagination (and still do so) included:

- improving access to health services;
- removing barriers to access;
- fairer health outcomes for Maori and Pasifika;
- improving the affordability of accessing health services;
- health care services closer to the end user (the 'consumer');
- improving communication between clinicians, communities, and individuals;
- supporting clinicians to make best use of their skills;
- supporting General Practice;
- broadening the debate about what 'health outcomes' mean;
- encouraging consumer education for the informed self-management of health needs.

Why are these goals so important? Because somehow, in New Zealand, we have widely disparate health outcomes. Despite everybody's good intentions, our health outcomes are significantly compromised if we:

- are poor ('low socio-economic demographic');
- have limited access to transport;
- are Maori or Pasifika;
- are rurally isolated;
- have low literacy;
- have nil or limited access to the Internet;
- dwell in 'cold' housing.

Why is the PHO Alliance so central to this discussion? Because it represents PHOs who are in the front line of the battle; bit by bit, members are hard at work helping to address these very issues. I see creative and innovative thinking and action. I see willingness to do things better, smarter, and more effectively. I see longer-term planning, and an emphasis on genuine partnerships of trust.

Unfortunately, I also see evidence of fearfulness, timidity, and vacillation; usually from our secondary health partners. There is a shift in culture requiring our support and encouragement. It is no longer acceptable for primary health to bewail our fate against secondary service inertia; we are all in this together, so we had better get together!

I am greatly encouraged by the strengths I see within PHO-land. However, it is timely for a review of just how the whole system will work together. The opportunity for a wider-based primary (and secondary) health network is opening up to us all. This is very significant. I exhort us to look beyond ourselves and imagine a health system that gets cracking; the disparities to which I alluded above may just melt away to become a footnote in the evolution of a fair and rational health system. Why not?

My heartfelt thanks go to you all for your support and encouragement. The Executive Committee has been a pleasure to work with, and what can I say about Michelle? Without such

a diligent EO, the PHO Alliance would be a shadow – Michelle keeps us astutely informed, advised, encouraged (and challenged). It has been a privilege to be a small part of this team. Please continue to keep up your good work. Thank you!

Mike Ward
Chairman
ward.wclt@xtra.co.nz

[As an Appendix, I include the Objects of PHO Alliance; as stated within our Constitution:]

3. OBJECTS/WHĀINGA

The objects of the Society will be to provide national leadership on key issues affecting the Primary Health Care Strategy (PHCS) and Primary Health Organisations (PHOs) in New Zealand. In particular the Society will:

3.1 Advocate on behalf of members for the benefit of their enrolled population.
3.2 Promote community health through PHOs.
3.3 Foster effective partnerships between providers and communities.
3.4 Foster and nurture key strategic relationships at a local and national level.
3.5 Encourage collaboration, information and resource sharing within the sector.
3.6 Contribute to the development and implementation of health policy at a national level.
3.7 Promote organised general practice as a cornerstone of PHOs.
3.8 Carry out other activities consistent with the charitable objects of the society.

EXECUTIVE OFFICER'S REPORT

As is my tendency, I like to begin my reports with a number - to indicate the length of time the PHO Alliance has been operating and a word - to best describe my impression of the year just gone. Last year it was "6" and "frenzy." This year, it's "7" and "integration". 19 is the number of members we currently have; covering a combined population of 2.95M New Zealanders. 2 new members have been welcomed into the fold: Manaia Health PHO and Te Tai Tokerau PHO and 1 has been farewelled: Harbour Health PHO.

Other words and phrases carrying political currency this year have been "there is no more money" and "the universal subsidy is here to stay." These twin constraints provide a significant challenge for reducing health disparities and for tackling the wider determinants of health – key functions of PHOs as espoused in the PHCS, but which have been difficult to achieve on any great scale.

Another expression gaining traction over recent months is that of "dual accountability." This is the concept that health players have responsibilities to their own organisations but also to the system as a whole e.g. DHBs have responsibilities to geographic regions but they also have responsibilities to the whole system. PHOs have responsibilities to their enrolled populations, their funders and their providers. And patients, in return for subsidised care, have a responsibility to help manage their health.

While there appears to be universal agreement that primary care needs to play a bigger role in the health sector, it can't do it alone. More guidance is required from the centre and the whole system needs to be incentivised to make this happen. As Dr Judith Smith recently said at the World Healthcare Networks Conference in Cairns, "the integrated health care challenges are both within and beyond primary care now." She sees this as an opportunity for the "development of clinically-led organisations working in the public interest or community-led organisations working in the professionals' interest".

The PHO Alliance has always supported the need for clinical leadership alongside community involvement – it is espoused in our charitable objects. However, as observed by the Executive Committee at last month's meeting there is a feeling that the clinical dimension is beginning to overshadow the pre-clinical dimension. This is concerning, because it is communities and their components of family, whanau and individuals providing for their own health and supporting each other in healthy lifestyles, which precedes clinical involvement and often prevents the need for clinical involvement.

The concept of creating a new national PHC organisation will be discussed at our AGM and other interested parties will also be in attendance. How this shakes out for PHOs and by implication the PHO Alliance remains to be seen. There is no doubt the next phase will be rocky; innovation and new ways of doing things are necessarily disruptive. What must remain, and be strengthened is genuine patient and community engagement in PHC, as this is the best way for the system to reach the potential expected of it.

In amongst all the churn it is important not to lose sight of life's bigger issues. Our Canterbury colleagues are not only dealing with a systems redesign but a redesign of their whole lives, workplaces and communities. Back in June Paul Wynards, Clinical Psychologist, from Rural Canterbury PHO, spoke to us about the critical importance of "psychological first-aid" in a major disaster. Neighbours and communities caring for one another, making sure people have enough food to eat and clothes to keep warm, is what got people through. This type of support was

deemed more helpful than contact with professionals in the immediate aftermath of the major earthquakes. Paul also spoke of Random Acts of Kindness (RAKs) and regularly checking in with people to see how they are going as critical to the recovery process – estimated to take the next 20 years.

During the past 7 years the PHO Alliance has been blessed with three highly competent chairs: Dr Richard Tyler (our foundational chair); Hamish Kynoch (our chair from the end of 2006 to September 2011) and Mike Ward (our current chair). Each has brought their unique skills and expertise to the role; all have shared a strong belief in the importance of community involvement, alongside clinical leadership. Each has been a pleasure to work with - as too have all the Chairs and CEs of our member organisations. As we near this year's AGM our future is the most uncertain it has ever been. However, with uncertainty and change comes opportunity. Opportunity to build on the best of what's gone before (of PHOs, PHC Networks, IPAs and others) so that the whole health system can do things better within the available resources.

Are we up for the challenge – you bet!

With every best wish

Michelle Thompson
Executive Officer
michelle@ceo2.co.nz

PRIORITIES AND DIRECTIONS ACHIEVED 2011-2013

The essence of the strategic focus for the two-year period 2011-2013 is supporting members to position themselves to cope with the actual and potential changes in the national scene while at the same time positioning the PHO Alliance as an organisation able to influence primary health care policy decisions.

To this end, the Executive Committee determined six high level strategic goals:

- To promote sharing of resources and activities amongst members.
- To build closer working relationships with the National Health Board, the Director General of Health and other parties as appropriate.
- To pursue engagement with DHB Chairs and Chief Executives.
- To demonstrate the value of PHOs in specific and general terms.
- To maintain and strengthen relationships with General Practice New Zealand, New Zealand Medical Association and other groups as appropriate.
- To support equitable health outcomes for Maori and Pasifika.

We recently added a 7th goal:

- To offer peer support to our Canterbury-based members.

The following table reports progress and activities against these objectives.

Priorities	Outcome Sought & Progress Update
Sharing of Resources & Activities	**High level outcome desired = Valuable repository of PHC resources built up**
	Members continue to share resources and activities on a regular basis via email. **<u>Clearing House</u>** Two main clearing house exercises undertaken during the year were: • **Satisfaction levels with DHB engagement and leadership** – Overall, PHO governors appear more satisfied with the current level of DHB relationships than PHO managers. There is evidence of good relationships occurring in some regions but in one or two regions the situation is described as having stagnated or gone backwards. The main concerns identified back in 2007 such as: a lack of primary health care knowledge and the non-alignment of Primary Health Care Strategy values amongst senior DHB staff; an over identification with secondary services; inertia with the primary-secondary clinical interface; an environment of over management and risk aversion; and conflicts arising as a result of DHBs being both a

provider and funder still persist five years on. PHO management particularly dislike the command and control tactics and the general master-servant approach still prevalent in many DHBs**.**

Key areas of disappointment in 2012 for both boards and management are:

- The level of involvement in this year's District Annual Planning processes despite this being a Ministerial and Ministry of Health directive;
- Slow progress being made on primary-secondary integration; and
- Poor relationships with key staff/groups. Relationships with general managers planning & funding; chief executives, DHB board members and members of the community and public health advisory committees could all do with improvement.

- **Changes to Community Pharmacy Model -** Overall, members were in support of the high level concepts underpinning the new service model. However, some significant concerns were identified, relating mainly to the lack of information available making it difficult to know whether the new model will be successful in the long-term. The concerns ranged from practical implementation issues such as alignment with prescribers and the absence of a standard IT platform through to fixed funding, perverse incentives and the potential for the new model to increase health disparities.

Website

A valuable repository of primary health care resources is being built up through the website. Although, over the past six months the uploading of documents has been slower than desired due to capacity issues. It is hoped this will be addressed in the next quarter. As a consequence, traffic volumes were down by approx 25% compared with the previous two years:

Public website www.phoalliance.org.nz

- 844 unique visitors made 1,095 visits, averaging 3 pages per visit and stayed approximately 2 minutes per visit.
- Most popular page was News and Announcements.
- Visitors came from 28 different countries, the top five of which were: NZ (932); USA (86); Australia (25); UK (8) and Canada (7).

Members only site www.phoalliance.org.nz/members/

- 12 unique visitors made 41 visits, averaging 3 pages per visit and stayed approximately 4 minutes per visit.
- Viewing peaked August-October 2011 and dropped off in recent months. Mainly due to time delay in posting relevant documents.

Closer Working relationships with NHB, DGH and others	**High level Outcome desired = Ability to influence PHC policy development and implementation through strengthened relationships**
	Specific objectives under this goal are mostly on-going in nature and have been achieved fairly well over the past 12 months: • Several Chair to Chair interactions have occurred during the year, including the sharing of "early thinking" on a range of topics. The PHO Alliance was part of the primary care delegation presenting to the National Health Board in July. Dr Murray Horn is guest speaker for the 2012 AGM. • Interactions have occurred between our Chair and the Executive Director of the NHB, including a request to disseminate information amongst our members and to provide feedback, for example, the Community Pharmacy Model. • PSAAP negotiations have also provided a useful way to engage with Ministry representatives. • Specific engagement with the Director General of Health – other than via his membership of the National Health Board – has been limited in the last 12 months.
Engagement with DHB Chairs & CEs	**High level Outcome desired = Ability to influence PHC policy development and implementation through strengthened relationships.**
	Most of the objectives under this goal are not set to get underway until the last quarter of this year and during 2013. NHB engagement has taken priority over DHB engagement during the last 12 months.
Demonstrate Value of PHOs	**High level Outcome desired = Values, principles and purpose of PHOs and PHO Alliance retained**
	The essence of this goal is to clearly demonstrate, with concrete examples, the following objectives: • The critical role primary health organisations play in getting community involvement in health; and • How primary health organisations can help DHBs meet the Minister's expectations This is deemed a critical piece of work in the next six months.
Relationships with GPNZ, NZMA and Others	**High level Outcome desired = Ability to influence PHC policy development and implementation through strengthened relationships.**
	Good relationships continue with GPNZ: • Chair to Chair interactions taking place on regular basis. • Management interactions taking place on a regular basis. • Joint PHOA/GPNZ PSAAP negotiating team working effectively. • Joint engagement with NHB.

	• Option on table to explore closer working relationships with GPNZ at the AGM. Networking opportunities will be sought with the GP Council of the NZMA in the next quarter.
Support Equitable Health Outcomes for Maori and Pasifika	**High level Outcome desired = Health disparities reduced**
	Good relationships are being established with Healthcare Aotearoa: • Joint PSAAP paper put forward outlining an urgent need to review the VLCA funding scheme so that practices catering for our most high needs patients remain sustainable. PHO Alliance PSAAP facilitator has been appointed to a sub-group to look at these issues as a priority. • Continued advocacy for a higher degree of targeted funding to those most in need. Although the political appetite for this remains low. • HCA representatives will attend the 2012 AGM. • Invitations to attend GMs have been extended to the Chair and CE of the National Hauora Coalition but competing demands on their part have made this difficult. • Clearing house exercise to assess investment in general practice by Maori, Pacific and community groups is set for the last quarter of 2012. As is, uploading members' Maori and Pasifika Health Plans to the website and conducting a survey to assess success factors and barriers to their implementation.
Peer Support & Understanding	**High level Outcome desired = PHO chairs and CEs in Canterbury feel supported as they seek to rebuild their organisations and their lives following the devastating (and on-going) earthquakes.**
	Following the somewhat harrowing bus tour of central Christchurch and surrounding suburbs in June it was decided to put in some long-term peer support for our Canterbury-based colleagues. For starters this will include activities such as: dedicated time at each GM to "check-in" with the Chairs and CEs to see how they are faring with the recovery process; providing for low-cost escapes for board members, management and staff of the three PHOs and RAKs.

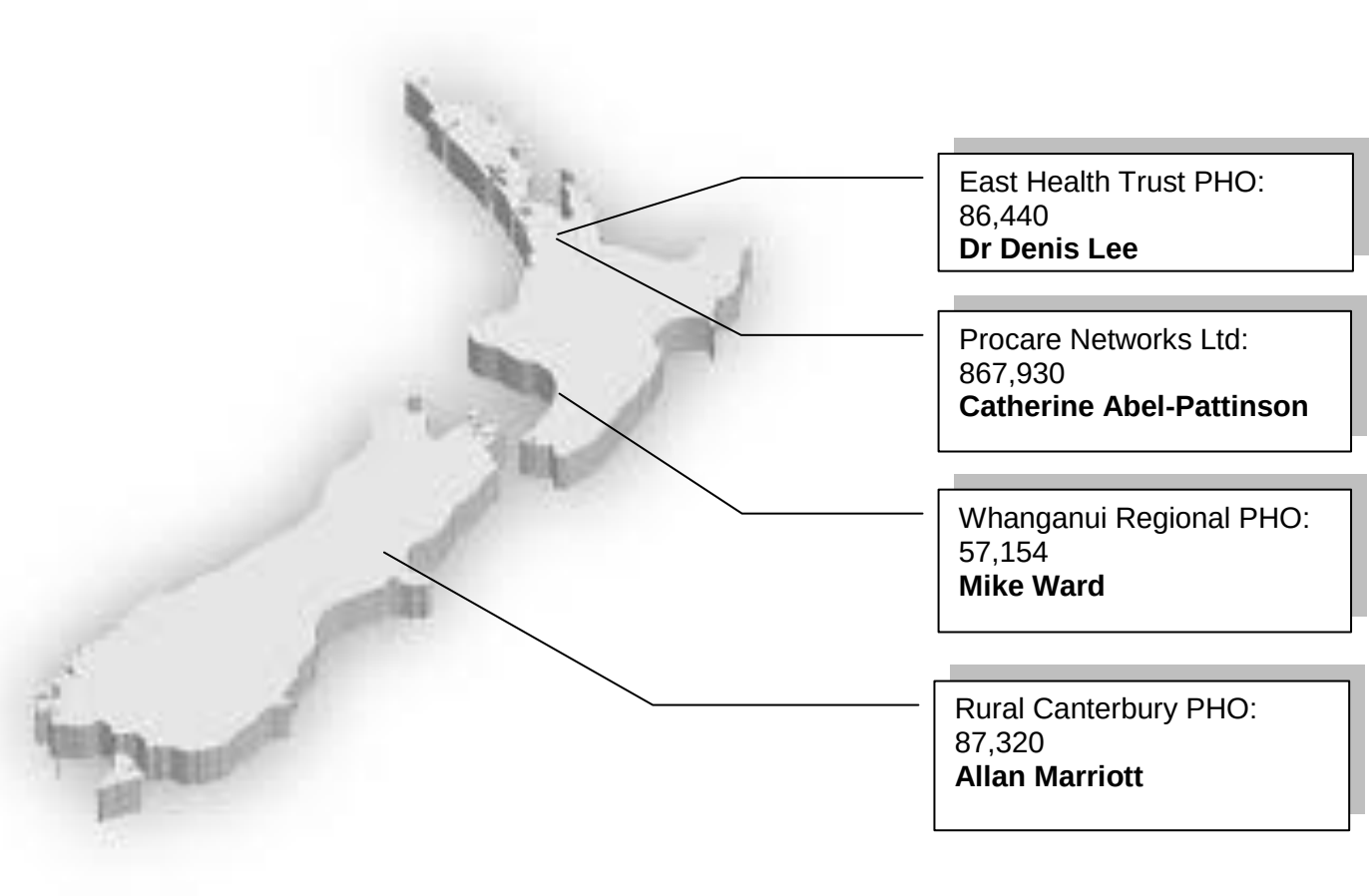
PROPOSED PRIORITIES AND DIRECTIONS 2012-2013

The new executive committee will meet following the 2012 Annual Meeting to review the strategic direction for the forthcoming year.

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 2011-2012 executive committee are included over the page. The map below shows respective geographical locations, enrolled populations and portfolios of responsibility.



Mike Ward – Chairperson (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.

Portfolio of responsibility: Media & Public Relations.

Dr Denis Lee – Executive (Elected)

- Chair of East Health Trust PHO.
- General Practitioner.
- Director of East Health Services Limited (MSO).
- Director East Care Limited (A&M).
- Honorary Senior Lecturer.
- Medical Examiner for CAA.
- Interest in aged and palliative care and in management of chronic conditions.

Portfolio of responsibility: Clinical.

Allan Marriott- executive (Elected)

- Chair of Rural Canterbury PHO.
- Background in education, community development, published writing and primary health.
- Particular interests in community and individual involvement, access for those isolated (remotely and economically), aged care, standards and best practice.

Portfolio of responsibility: Community.

Catherine Abel-Pattinson- Executive (Elected)

- Senior Manager, ProCare Health.
- Broad knowledge of the primary health sector from a provider, clinical and management perspective.
- Previous roles have been in the biotech industry and hospital management.

Portfolio of responsibility: Management.

Hamish Kynoch – Chairperson (Co-opted)

- Immediate past chairman of Hawke's Bay PHO and PHO Alliance.
- Background in NGO and community governance, and local government.
- A farmer with a non-clinical community perspective.

LIST OF MEMBERS @ August 2012

Member PHOs	Date Joined	Enrolled Pop @ Apr-12	Chair	DHB	PHO Street Address
Central PHO	1-Jul-10	152,690	Colin McJannett	MidCentral	575 Main St, Palmerston North
Compass Primary HealthCare Network	1-Jul-10	243,078	Dr Larry Jordan	Capital & Coast	Level 7, Freemason House, 195-201 Willis St, Welllington 6011
Christchurch PHO	22-Aug-06	30,966	Dr Angus Chambers	Canterbury	Level 2, 160 Bealy Ave, St Albans, Christchurch
Eastern Bay Primary Health Alliance	1-Jul-11	46,002	Dr Bryan Gould	Bay of Plenty	29-31 Richardson St, Whakatane, 3120
East Health Trust PHO	30-Jun-06	86,440	Dr Denis Lee	Counties Manukau	Building B, 260 Botany Road, P O Box 38-248, Howick, Auckland
Health Hawkes Bay	1-Apr-11	152,343	John Newland	Hawkes Bay	Staples Rodway Building, Cnr Lyndon Road and Hastings St, Hastings
Health Rotorua PHO	25-Jul-06	71,715	Dr Russell Burton	Lakes	Unit 2, 55 Marguerita St, Rotorua
Kimi Hauora Wairau Marlborough PHO	7-Aug-06	42,258	Joe Puketapu	Nelson Marlborough	Level 4, Cavalier House, Cnr Market St/Alfred St, Blenheim
Manaia Health PHO	7-Feb-12	93,090	Dr Andrew Miller	Northland	28-30 Rust Avenue, Whangarei
Nelson Bays PHO	29-Sep-06	94,597	John Hunter	Nelson Marlborough	20 New Street, Nelson
Partnership Health Canterbury PHO	15-Aug-06	366,404	Prof Andrew Hornblow	Canterbury	56 Shirley Road, Christchurch
ProCare Networks	1-Jan-11	867,930	Dr Harley Aish	Auckland/Counties Manukau	Level 2, 110 Stanley St, Grafton, Auckland
Rural Canterbury PHO	10-Aug-06	87,320	Allan Marriott	Canterbury	2/567 Wairakei Road, Christchurch, 8053
Southern PHO	15-Feb-11	285,512	Stuart Heal	Southern	1 Bond St, Dunedin 9054
Te Tai Tokerau	4-May-12	60,919	Georgina Martin	Northland	182 Commerce St, Kaitaia, 0441
Wairarapa Community PHO Trust	30-Jun-08	41,490	Elaine Brazendale	Wairarapa	Level 1, 49-52 Lincoln Road, Masterton
West Coast PHO	27-Feb-09	31,312	John Ayling	West Coast	Level One, 163 Mackay St, Greymouth
Western Bay of Plenty PHO	25-Jul-06	144,445	Dr John Gemming & Paul Stanley	Bay of Plenty	126, Eleventh Avenue, Tauranga
Whanganui Regional PHO	10-Aug-06	57,154	Mike Ward	Whanganui	Level 1, 76 Guyton St, Wanganui
TOTAL -PHO ALLIANCE		**2,955,665**			

FINANCIAL STATEMENTS

Summary of financial performance 1 July 2011 – 30 June 2012

The PHO Alliance's income receipts for the twelve months ending 30 June 2012 were $157,509 and total expenditure was $176,031 resulting in a net operating deficit of $18,522 (against a budgeted year-end deficit position of $18,490).

The main expenditure items were management and financial services (60%), executive fees and expenses (14%), back to back contract expenses (13%) and PSAAP expenses (9%).

Total equity as at the end of the sixth year of operation is $48,468. Cash in the bank is $43,623.

Summary of main differences between Actual Income & Expenditure 2012 and 2011

Total income in 2012 was $26,529 more than in 2011 for the following reasons:

- $5,750 more in membership levies.
- $8,000 more in contract income resulting from sale of back to back template packages.
- $12,779 more in other income due to a combination of transferring the governance development funds from the balance sheet into consolidated funds and receiving less interest on term deposits.

Total expenditure in 2012 was $25,529 more than in 2011 for the following reasons:

- $14,620 for a further revision of the back to back contract template.
- $5,888 additional expenditure on executive fees and expenses associated with transitional activities.
- $4,129 additional expenditure on PSAAP activities associated with increased meetings and transitional activities.
- $1,019 additional telephone expenditure relating to the above two items.

PHO ALLIANCE
INCORPORATED

FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2012

DIRECTORY

PHO ALLIANCE Inc
STATEMENT OF FINANCIAL PERFORMANCE
FOR THE YEAR ENDED 30 JUNE 2012

	2012 $	2011 $
Income		
Membership Fees	129,750	124,000
Contract Income	12,000	4,000
Other Income	15,759	2,980
Total Income	**157,509**	**130,980**
Expenses		
Back-to-Back Contract	22,732	8,112
Bank Charges	204	206
Catering	863	1,161
Depreciation	696	1,166
Executive Fees & Expenses	24,848	18,960
Management & Financial Services	106,100	106,100
National Sector Representation	805	0
PSAAP Expenses	16,300	12,171
Sundry Expenses	50	257
Telephone	2,083	1,019
Venue Hire	1,350	1,350
Total Expenses	**176,031**	**150,502**
Net (Deficit)/Surplus	**(18,522)**	**(19,522)**

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 2012

	2012 $	2011 $
Opening Balance as at 1 July	**66,990**	**86,512**
plus (Deficit)/ Surplus for the year	(18,522)	(19,522)
Total Recognised Revenues and Expenses for the Year	(18,522)	(19,522)
Closing Balance as at 30 June	**48,468**	**66,990**

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 2012

	2012	2011
Assets	**$**	**$**
Current Assets		
Bank Accounts	43,623	76,845
Accounts Receivable	2,300	3,047
GST Receivable	2,714	4,684
Total Current Assets	**48,637**	**84,576**
Fixed Assets		
Web Site	**656**	**1,261**
Total Assets	**49,293**	**85,837**
Liabilities		
Current Liabilities		
Accounts Payable	825	4,703
Governance Development Pre-payments	0	14,144
Total Current Liabilities	**825**	**18,847**
Net Assets	**48,468**	**66,990**
Equity		
Retained Earnings	48,468	66,990
Total Equity	**48,468**	**66,990**

Signed by:

Chairperson

Executive Officer

Dated: 14 August 2012

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 2012

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 under 3 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.

PHO ALLIANCE Inc
NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2012 Con't

5. Fixed Assets

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

6. Financial Operations

This is the 6th financial year the PHO Alliance has been operating.

7. Auditors

For the year ending 30 June 2012, the PHO Alliance Inc has not appointed auditors.