National Aboriginal Community Controlled Health Organisation

NACCHO ANNUAL REPORT 2009–2010

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NACCHO is the national peak body representing Aboriginal Community Controlled Health Services. It is a public company limited by guarantee, not having a share capital, and was incorporated under the Commonwealth Corporations Law provisions by the Australian Securities Commission in June 1997. ABN 89 078 949 710.

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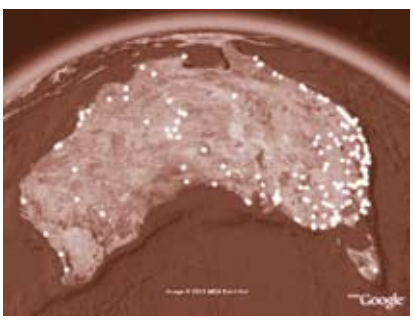
ABOUT NACCHO

The National Aboriginal Community Controlled Health Organisation (NACCHO) is a living embodiment of the aspirations of Aboriginal communities and their struggle for self-determination.

NACCHO is the national peak body representing over 140 Aboriginal Community Controlled Health Services (ACCHSs) across the country on Aboriginal health and well being issues. It has a history stretching back to a meeting in Albury in 1974.

In 1997, the Federal Government funded NACCHO to establish a Secretariat in Canberra which greatly increased the capacity of Aboriginal Peoples involved in ACCHSs to participate in national health policy development.



Map of Australia showing the location of the over 150 member services of NACCHO.

An ACCHS is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management.

In keeping with the philosophy of self-determination, Aboriginal communities operate over 140 ACCHSs across Australia. They range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services without medical practitioners, which rely on Aboriginal health workers and/or nurses to provide the bulk of primary care services, often with a preventive, health education focus. The services form a network, but each is autonomous and independent both of one another and of government. The integrated primary health care model adopted by ACCHSs is in keeping with the philosophy of Aboriginal community control and the holistic view of health that this entails.

'Aboriginal health is not just the physical well being of an individual but is the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life.'

(National Aboriginal Health Strategy, 1989).

The solution to address the ill health of Aboriginal people can only be achieved by local Aboriginal people controlling the process of health care delivery. Local Aboriginal community control in health is essential to the definition of Aboriginal holistic health and allows Aboriginal communities to determine their own affairs, protocols and procedures.

Thus, NACCHO represents local Aboriginal community control at a national level to ensure that Aboriginal people have greater access to effective health care across Australia. NACCHO provide a coordinated holistic response from the community sector, advocating for culturally respectful and needs based approaches to improving health and well being outcomes through ACCHSs.

NACCHO's work is focused on:

- Promoting, developing and expanding the provision of health and well being services through local ACCHSs
- Liaison with organisations and Governments within both the Aboriginal and non-Aboriginal community on health and wellbeing policy and planning issues
- Representation and advocacy relating to health service delivery, health information, research, public health, health financing, health programs, etc
- Fostering cooperative partnerships and working relationships with agencies that respect Aboriginal community control and holistic concepts of health and well being.

REPORTS

Chairperson's Report

It is now a year since my election to the position of NACCHO Chairperson. Having worked in the Community Controlled Health Sector for the majority of my working life I have often reflected on the strength, dedication, knowledge and resilience of our Sector. However, it was my election to the position of NACCHO chair that reinforced not just the privilege of representing our membership but the enormity of this responsibility. The responsibility to ensure that the words spoken at my election and the membership's 'wish list' for focusing and moving our agenda forward were not merely polemic (words) but contained real action behind them.

My vision was and remains for NACCHO to continue as a vibrant and relevant national representative organisation; that regardless of the political environment we maintain and develop meaningful partnerships and relationships with key-stakeholders; that we occupy a central role in determining the direction and fair allocation of health funds to Aboriginal Community Controlled Health Services and that we continue to lobby and represent our membership at a national level to ensure our voices resonate strongly.

My and the NACCHO Board's core motivation for all of NACCHO's work is our membership and whether this work benefits our communities? Without our membership's strong dedication and commitment to providing the highest quality medical services to their communities there would be no national organisation to advocate on behalf of. The key to a cohesive Sector is not merely holding similar aims and goals but communicating effectively by sharing information and providing support and advice. Therefore, despite the external demands for NACCHO's time and expertise, during my first term I considered it a priority to focus internally by prioritising meeting with our Affiliates and visiting a diverse range of our Community Controlled Health Service members – rural, remote and urban – to seek a thorough understanding of the issues that confront and challenge you as our members, your success and the supports required from NACCHO.

Over the past year I have visited many of our member services. These visits have been a highlight of my year as they allowed me to take stock and consider the remarkable achievements in the sector. It has provided me with the opportunity to meet and witness first hand the full range of impressive, talented and dedicated people involved in the Aboriginal Community Controlled Health Sector. The Sector is comprised of many professional and dedicated people.

It is this grass roots perspective that informs the basis for providing advice, input and advocacy for the Sector at a national level. It is humbling to consider that despite lack of resources and the unrelenting demands on our services that the Aboriginal Community Controlled Health Sector has built an effective voice and developed many significant

partnerships to enable our agenda and voices to be heard by all levels of government. This could not have been achieved without 'taking stock' of the Members concerns, successes and achievements. The fact that our Members have been able to achieve significant gains in policy and funding directions is a testament to our Sector's strength. A strength that cannot be underestimated as we continue to build stronger and more robust relationships with existing and new partners and other stakeholders

Over the next 12 months, I remain committed to continuing to visit our Member services and Affiliates to learn how to better communicate the diversity of opinion and concerns at a national level. This internal focus will allow NACCHO to prioritise our external activities that include representing our membership on the increasing number of committees, working groups, events and conferences, requests for technical advice and research assistance.

Additional internal focuses over this period has included maintaining and increasing governance skills of NACCHO's Board and implementing the review of the NACCHO Constitution. We are strengthening relationships and communication across the Sector as we shift the strategic direction of the organisation towards more innovative ways of doing business in the current political climate. The NACCHO Board has a commitment to ensure our membership is continually strengthened across all areas and that we can support and advocate for Aboriginal Communities whom aspire to initiate their own Aboriginal Community Controlled Health Organisations.

We have also been kept extremely busy with the external demands placed upon our Sector due to the rapid changes in Aboriginal health policy, program development and increased investment instituted largely by the Federal government through the Council of Australian Governments (COAG). While we welcome the increased investment in Aboriginal health, it appears that Aboriginal Community Control Health Services have not benefited. The concern remains that the new funding is being directed towards mainstream services at the expense of the Aboriginal Community Controlled Heath Sector.

NACCHO continues to emphasise the need for a genuine, equal and consultative partnership in our many meetings with the elected arm of Government, the bureaucracy and other stakeholders. We continue to lobby government and other stakeholders regarding our concerns that funding allocations seek to mainstream Aboriginal health under the guise of 'making the mainstream health system more responsive to Aboriginal people'. Our message is clear - the best return on investment for improving Aboriginal health outcomes is through Aboriginal Community Controlled Health Services. This message is actively advocated through the media, our committee membership and with our members during parliamentary lobbying days to ensure it remains on the government's agenda.

It is not possible to give justice to the range of activities undertaken during the year. Often the work is reactive and my challenge as Chair has been to determine how to both meet these external challenges whilst attempting to set the agenda and work strategically. To highlight some of the challenges and successes for NACCHO I have outlined some of the external influences and our responses as follows:

- *NACCHO sought to cement the Community Controlled Health Sectors role as a recognised Primary Health Care Provider for Aboriginal Peoples.*

Through our partnerships, meetings with the bureaucracy, our lobbying for a national Framework Agreement and our input into significant reform processes NACCHO has explored how to achieve recognition for our Sector as the principal provider of culturally safe and appropriate service providers of primary health.

The principal instrument through which consultation was sought, and to which NACCHO responded in a comprehensive primary health care submission focused on the Aboriginal Community Controlled Health Sector, was the Federal Government's *National Health and Hospital Reform Commission report*. Despite assurances the report would address Aboriginal health very little changed for our Sector.

NACCHO also held a successful meeting of Peak Aboriginal Health Bodies. Representatives from a number of organisations came together and collectively discussed how we can best work together in the ever-changing environment of Aboriginal Health.

The meeting created an opportunity to have the space and time to discuss how we, as peak bodies, can better strengthen and support each other as we collectively work towards building an healthier and stronger Aboriginal Australia, we discussed how we can strengthen our combined national voices and our relationships with each other. It is envisaged that other meetings such as this will occur in the future.

- *NACCHO sought to examine the impact of and explore any potential role for the Community Controlled Health Sector in the proposed Medicare Locals.*

The centrepiece of the government's new 'localised' primary health care strategy was the proposal to create 'Medicare Locals' across Australia. However, the role for Aboriginal Community Controlled Health was not considered. Given the extensive changes proposed, significant funds designated for implementation and their potential function and operation within the sphere of Aboriginal health, a meeting of Affiliates and Members was held to discuss the Sector's position regarding the Federal Government's primary health care reforms and establishment of Medicare Locals.

Despite the complexities of the new reforms the Sector determined the way forward was to advocate for the establishment of 'Indigenous Australian Primary Health Care Organisations' located in urban, regional and remote regions. The focus being to coordinate primary health care services for the Aboriginal and Torres Strait Islander population, covering issues such as regional planning and development, quality improvement, regulation compliance, performance management, identification of areas of "market failure" and addressing gaps in access to appropriate services.

Similarly to the Australian General Practice Network, NACCHO must be resourced to develop and implement a transition strategy to the new structures. As a minimum requirement NACCHO representation on the committee overseeing the implementation of the mainstream Medicare Locals is essential to ensure our Sector's interests, role and function as primary health care providers is both understood and respected.

- *The changing political environment continues to impact upon our responses and role in the myriad of programs being implemented*

NACCHO acknowledged and thanked Kevin Rudd for his moving apology to the Stolen Generations, for his focus, attention and commitment within the Federal government and through COAG to 'Closing the Gap' in life expectancy and seeking to improve health outcomes between Aboriginal and non-Aboriginal Australia.

NACCHO welcomed Ms. Julia Gillard as our 27th Prime Minister, and expressed our commitment to continuing our work with Health Minister Roxon and Indigenous Health Minister Snowdon. The aim being to continue contributing to all discussions and programs designed to improve Aboriginal Primary Health Care and solidify a real partnership where NACCHO's expertise in the delivery and design of services to the Aboriginal community is recognised and acted upon.

I believe the following 12 to 18 months presents us with the opportunity to further embed NACCHO and our Members as **the** leaders in Aboriginal health as we work with the Australian Government to build stronger relationships. The current political environment has changed dramatically over the past three years. Our challenge is to present a collective united front to actively challenge current trends towards greater mainstreaming and present an effective model to 'Close the Gap' in Aboriginal health across the nation.

In closing I would like to thank everyone who has supported me in my new position as Chair of NACCHO. Without you, it would not be possible to achieve the enormous outputs and outcomes that our Aboriginal Community Controlled Health Sector is able to whilst focusing on servicing the health needs of our communities and negotiating the changes of Government policy and direction. Despite our fight to be heard being limited by the pressures of service delivery and under resourcing I believe our voice is becoming stronger. NACCHO will continue to highlight at every opportunity this message: that the Aboriginal community has an expert, professional, talented, dynamic, robust and cutting edge Primary Health Care system. It is called Aboriginal Community Controlled Health. Let us continue the great work we have collectively been able to achieve thus far, while we explore and develop new opportunities that will further strengthen and embed our Sector within the new Australian health care system.

Mr Justin Mohamed
Chairperson

THE NACCHO Board

The over 150 member ACCHSs (endorsed by our Affiliates) directly elect the 16-person NACCHO Board. It is made up of one delegate each from the ACT and Tasmania; two delegates each from the remaining six jurisdictions, and a Chairperson and Deputy Chairperson.

Elections for the delegates to the NACCHO Board are held annually to coincide with each Affiliate's Annual General Meetings. However the full membership (at biennial Annual General Meetings of NACCHO Members) elects NACCHO's Chairperson and Deputy Chairperson for two year terms.

The NACCHO Board's role is to meet four times each year to:

- Make decisions regarding the strategic policy directions of the organisation;
- Develop, monitor, review and make continual improvements to NACCHO's Action Plans; and
- Maintain and strengthen the connections between the Membership and the NACCHO Board.

NACCHO Board Members at 30 June 2010 were:

Mr Justin Mohamed – Chairperson

Mr Justin Mohamed was elected NACCHO Chair at the Annual General Meeting in November 2009.

He is a Gooreng Gooreng man from Bundaberg Queensland but he has lived and worked with Victorian Aboriginal communities for the last 20 years.

Over this time he has been part of the community controlled Aboriginal health sector including as the Chairperson, and former CEO, of Rumbalara Aboriginal Co-operative and Director of the Academy of Sport, Health and Education in Shepparton.

Mr Mohamed chaired the Victorian Aboriginal Community Controlled Health Organisation, NACCHO's affiliated peak body for six years and he served as NACCHO's Deputy Chair for two years.

Glenda Humes – Deputy Chairperson

Glenda is the CEO of the South West Aboriginal Medical Service (SWAMS) in Bunbury Western Australia. She is originally from Victoria and has spent many years living in NSW and the ACT and working in Aboriginal Affairs for state and federal governments. Some of you will remember Glenda as the Deputy CEO of NACCHO until her departure to work at SWAMS in 2004.

Since moving to WA Glenda is very involved with the state affiliate the Aboriginal Health Council of WA (AHCWA) especially with the Board and more recently on the AHCWA technical team on COAG. In 2008 SWAMS was successful in gaining a highly commended

award in the National Reconciliation governance awards. In 2007 Glenda travelled to New Zealand, Canada and Alaska with Darrly Kickett (then CEO of AHCWA) and Vicki O'Donnell (CEO of Derby Aboriginal Health Service) to visit Indigenous and First Nation communities on why they have been successful in closing the life expectancy gap of their peoples. This very valuable experience has changed the way in which Glenda now addressing health outcomes for Aboriginal people in Australia and especially WA and governance issues.

Glenda has a law degree and a Masters degree in Indigenous Social Policy

Western Australia

Phillip Matsumoto

Phillip was born in Broome and has been an active advocate in Aboriginal health, housing and education for the past thirty years. Phillip also holds the positions of Chairperson of Broome Regional Aboriginal Medical Service, Vice-Chair of AHCWA, and is a current KAMSC Board Member. Philip holds a Diploma in Aboriginal Community Development and is a Justice of Peace. Philip finds that being on a Health Board has given him the knowledge and understanding what we as Aboriginal people are striving for to deliver better health and living conditions to our people.

Lorraine Whitby

Lorraine Whitby is a Yamatji woman from the Gascoyne region of West Australia. She has been the Chairperson of Carnarvon Medical Service Aboriginal Corporation (CMSAC) since 2002.

Lorraine was elected for four terms to ATSIC, three terms in Perth, the fourth in the Midwest on the Yamatji Regional Council. She served as Acting Chairperson, Deputy Chairperson and Regional Councillor.

She has served on the Karlkarniny Regional Council, Perth Nyoongar Regional Council, the Police Minister's Council on Aboriginal Community Relations, Yamatji Regional Council, the Aboriginal Legal Service of WA, the National Aboriginal and Islander Legal Service, the Secretariat of National Aboriginal Islander Childcare, the Perth Employment Enterprise Development Aboriginal Corporation, the Gurlongga Njininj Childcare Centre and Carnarvon Medical Service Aboriginal Corporation.

Lorraine is currently an Executive Committee Member of Aboriginal Legal Service of WA for Murchison and Gascoyne Region.

New South Wales

Christine Corby

Christine is a Gamilarai woman whose mother's family originates from the Walgett-Collarenebri region in the northwest of NSW. Her father was English. Christine has lived and worked in Walgett for the past 25 years, the first 11 with the Aboriginal Legal Service and the past 19 as the CEO of the Walgett Aboriginal Medical Service (WAMS). Over the past 19 years Christine has overseen the growth of WAMS to a medical service that delivers a comprehensive range of primary health care services. Christine is a strong advocate for localised training programs; innovative services that reflect the community needs and has always been known to put forward strong arguments and representation on these and many other issues. Christine maintains a very broad involvement in all levels of health through her role on the executives of both the national and State Aboriginal health organisations, the AHMRC and NACCHO. Christine has a Diploma in Health Sciences and a Graduate Diploma in Health Services Management. She is also a recipient of the Centenary Medal and an Order of Australia Medal. The Order of Australia Medal was awarded to Christine Corby on account of her tireless commitment and dedication to improving the health and welfare of Aboriginal and non-Aboriginal people in Walgett in addition to recognising her outstanding contribution at Regional, State and National levels on behalf of all Aboriginal people.

Val Keed

Val was born in Peak Hill, NSW, and is a proud Wiradjuri woman. Val is Chairperson of the Peak Hill Aboriginal Medical Service, a board member of the Aboriginal Children's Service in Sydney and a member of the Central Southern NSW Aboriginal Legal Service in Wagga.

Val serves as the national representative for NACCHO on the Australian Health and Medical Research Council (AH&MRC). Additionally, Val has long been involved in the Aboriginal housing sector and serves on community boards in the nearby NSW towns of Forbes and Cowra that oversight drug and alcohol and social and emotional well-being programs. Val currently holds the position of Treasurer of the Weigelli Drug and Alcohol Centre, Cowra.

Val Keed replaced David Kennedy as a NACCHO Board member for NSW in November 2009.

Australian Capital Territory

Julie Tongs

Julie is a Wiradjuri woman born in Leeton NSW and grew up in a small country town called Whitton. Julie moved to the ACT region 36 years ago, where she now lives. Julie's long history of community service and involvement in the ACT has provided her with a strong knowledge and understanding of the issues impacting on Aboriginal people in the ACT

and region. Julie has been involved with Winnunga Nimmityjah Aboriginal Health Service (AHS) for some 15 years. Julie was elected by the community as a Director on the Board 14 years ago and was appointed the CEO 9 years ago. Julie has and continues to represent the ACT and Winnunga Nimmityjah AHS on many local and national steering committees and has been a Director on the NACCHO Board for nine years. In this way Julie has gained a vast amount of knowledge and experience at a national representative and strategic planning level.

South Australia

Yvonne Buza

Born in Wallaroo and belonging to the Walker family of Point Pearce, Yvonne spent her early years with her large family and the Narrunga people on the York Peninsula coast later moving to Roxby Downs in the Northern and Far Western Region of South Australia where she now resides.

Yvonne attended Adelaide University and began her career as a Teacher of English as a Second Language and went onto spend many years working with Aboriginal children in very isolated communities in the APY lands. Yvonne has since worked in policy and planning roles in Aboriginal education and health and acts in a senior advisory role to country health SA. She is the current Chairperson of the Northern and Far Western Aboriginal Health Advisory Committee, Secretary of AHCSA and an active member to many other Aboriginal community representative groups, including the Aboriginal State-wide Women's Advisory Committee. In her spare time, Yvonne teaches Aboriginal language and dance and privately tutors Aboriginal students in Country SA.

John Singer

John's family is from Ngaangtjara, Pitjantjatjara and Yankunyatjara Lands, which is the cross border area of Northern Territory, South Australia and Western Australia. He began working in community control at the Ceduna Koonibba Aboriginal Health Service where he started his health worker training, which he later completed in the late 1980s with the Nganampa Health Council. He worked in Community Administration from 1989 to 1996 at Iwantja, Fregon, Pukatja and Papunya. In 1997, he became the Manager of Iwantja Clinic, which is one of Nganampa Health Council's clinics. In 2000, he was appointed Director of the Nganampa Health Council and still currently holds this position. Over the years, he has participated on several Boards and Committees. Currently, he participates on the following Boards:

- National Aboriginal Community Controlled Health Organisation
- Aboriginal Health Council of SA Inc (Nganampa Health Council's representative since 1998 and Chairperson: 2005, 2006–current)
- CHSA Board (Country Health SA)
- Anangu Remote Health Alliance (influential in establishing this group in 2005. Chairperson: 2005 and 2006)
- Centre for Clinical Research and Excellence in Aboriginal and Torres Strait Islander Health (a joint partnership between the Aboriginal Health Council of SA Inc and Flinders University)

He has good understanding of governance, community control and government structures and is very committed to improving the health and well being status of Aboriginal people.

Tasmania

Raylene Foster

Raylene Foster is a Palawa woman born in Hobart. She currently holds the position of Chief Operations Officer at the Tasmanian Aboriginal Centre and Manager of the Aboriginal Health Service in Hobart.

She has been working with the Tasmanian Aboriginal Centre for the past 14 years in a variety of roles including as the Workforce Information Policy Officer and in the Social and Emotional Wellbeing regional centre. This is Raylene's second stint on the NACCHO Board after serving on it in 2002.

Queensland

Elizabeth Adams

Lizzie, a Mardigan Aboriginal woman, is the Chairperson of the Queensland Aboriginal and Islander Health Council and the CEO of Goolburri Health Advancement Aboriginal Corporation. She is also the Deputy Chairperson of the Aboriginal and Torres Strait Islander Corporation of Health, Education and Training.

Lizzie began her career in nursing and Aboriginal Affairs in the early eighties. She has worked for a range of Aboriginal Community Controlled Organisations such as housing, legal, education and health. It is these experiences and opportunities that have forged Lizzie's commitment to the rights and health of Aboriginal and Torres Strait Islander people.

Lizzie plays an active role in the Aboriginal and Torres Strait Islander community. It is through this active participation that Lizzie strives to work towards maintaining and improving the social, economic and cultural status of Aboriginal and Torres Strait Islander people at the local, State and National levels.

Sheryl Lawton

Born at Augathella, near Charleville in Queensland, Sheryl is currently CEO of the Charleville Western Area Aboriginal and Torres Strait Islander Corporation for Health. This appointment follows a life-time of experience and involvement in primarily community based organisations in the Charleville area. On finishing high school, Sheryl has added to her education through courses at TAFE and at the Mt Gravatt Teachers College in Brisbane. Sheryl holds a Certificate 4 in Governance (Business) and a Diploma in Business Management.

Positions held include Secretary/Treasurer of the Charleville Aboriginal Housing Company, Chairperson/Administrator of the Mitchell Aboriginal Housing Company, Chairperson and Deputy Chairperson of ATSIC's Goolburri Regional Council and Administrator of the Goolburri Aboriginal Land Corporation.

Other positions held include membership of the Joint Ministerial Advisory Committee on Housing from 1989 to 1996 and has been the Deputy Chairperson of QAIHC for the past four years.

Northern Territory

Stephanie Bell

Stephanie, a Kullilla/Wakka Wakka woman, is the Director of the Central Australian Aboriginal Congress. She is also: Chairperson of the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT); Chair of the Central Australian Remote Health Development Service; Chair of the NT Aboriginal Health Forum; a member of the Territory's key government/non-Government Aboriginal Health Partnership Committee; and, is a current Board member of the CRC for Aboriginal and Tropical Health.

Paula Arnol

Paula was born and raised in Cairns, her mother's family originates from Yarrabah in the far north Queensland region. Paula has lived in Darwin for the past 20 years and is the proud mother of 3 children, whom one is currently studying medicine at Melbourne University. Paula is an active member in her community through her children's sports and other activities. Paula's favourite pastime is listening to the old people reminisce and tell their stories of when they were younger.

Paula is a strong advocate for localised training programs; innovative services that reflect the community needs and has always been known to put forward strong arguments and representation on these and many other issues. Paula maintains a very broad involvement in all levels of health through her job as the CEO of Danila Dilba Health Service and her role on the following Boards, NACCHO, AMSANT (Aboriginal Medical Services Alliances Northern Territory) and Corporate Research Centre for Aboriginal Health.

Victoria

Andrew Gardiner

Andrew is a Wurundjeri man from Melbourne of the Woiwurrung speaking people of the Central Kulin nation. His family relation extends to Terrick, Wandin and Nevins.

Andrew is the Chief Executive Officer of the Dandenong and District Aborigines Co-operative Ltd (DDACL) in Victoria. The Co-operative

provides Primary Health and Allied Health services as well as Home and Community Care services, Koori Maternity services, Mental Health services, Youth services, Family services and Innovation Project services, Aboriginal Best Start (early childhood learning) services and Stolen Generations services.

He has been the DDACL representative to Victorian Aboriginal Community Controlled Health Organisation (VACCHO) Members Meetings since 2006 and a Member of VACCHO's Board of Directors since 2008 and the Vice Chairperson of VACCHO since 2009. Andrew joined the Board of NACCHO in 2009.

Lyn McIness

Born in Wynyard, Tasmania, Lyn is a Palawa woman Plangermairreener of Ben Lomand/ Portland/ Wathaurong country and is the mother of three sons and grandmother of five.

Lyn holds a Bachelor Degree in Applied Sciences majoring in Health Promotion. She has worked in the field of Aboriginal Health for 28 years and has been involved in Aboriginal Affairs since the late seventies.

Lyn is the Aboriginal Hospital Liaison Officer in the Department of Aboriginal Health, Geelong Hospital, Barwon Health, with 27 years service in the program which is community driven in a mainstream, best practice setting.

Some of the positions Lyn has held include being a ASTIC Regional Councillor, Tumbukka 1990–1993, a member of the Victorian health resources group, Chairperson of the State Women's and Children's executive, member of the Tripartite Council of Koori Health, Chairperson of the state HACC working party, Director of the Victorian Community Services Association, Director of the Victorian Aboriginal Legal Services, Chair and Vice Chair of Mirimbiak Nations Aboriginal Corp, and current Chairperson of Wathaurong Aboriginal co-operative and a director for 25 years. Lyn is involved in various other committees on a local, state and national level. Lyn is an elder in her community, Chairperson of the Elders group and is a Victorian Native Title member.

Lyn is a recipient of the Australian Centenary Medal in recognition of her achievements in Aboriginal health in Geelong. She wore the traditional possum skin cloak in the Melbourne Commonwealth Games opening ceremony.

Lyn is a current executive member and past Chairperson and Vice Chairperson of VACCHO

She is Chief Investigator in the Talking about Aboriginal pregnancy and post natal care project funded by NHMRC and is on the committee of the Deakin University Medical School Indigenous project.

Lyn still finds time to be involved with the youth of her community in sport and performing arts, where the youth are involved in projects in the Wathaurong language and involving Wathaurong medicine.

Lyn is a one eyed AFL Cats supporter and for relaxation she reads, is interested in most water sports, enjoys listening to music of all types and spending time with her family and grandchildren.

SECTOR CHART

CHAIRPERSON – JUSTIN MOHAMED

DEPUTY CHAIRPERSON – GLENDA HUMES

NACCHO CANBERRA SECRETARIAT

Chief Executive Officer – Dea Delaney Thiele, Senior Policy Officer – Janine Engelhardt, Policy Officer Public Health – Dr Sophie Couzos, Operations Manager – Elaine Lomas, Communications Officer – Chris Hallett, Finance Officer – Andrew Engelhardt, Assistant Finance Officer – Lisa Huang, Policy Officer (Workforce) – Denise Burdett, Policy Officer (Sexual Health) and Men's Health Policy Officer – Mark Saunders, Good Medicines Better Health Policy Officer and Women's Health Policy Officer – Irene Peachey, Research Policy Officer – Katherine Baverstock, Policy Officer – Linda Banach, Policy Officer (QUMAX) – Vicky Sheedy, Health Information Policy Officer – Anthony Carter, Special Projects Policy Officer – Maurice Shipp, Executive Assistant – Richard Chalk, Receptionist – Stefanie Darcy.

NACCHO QLD BOARD REPS

Elizabeth Adams
Sheryl Lawton

QLD MEMBERS
(AS ADVISED BY QAIHC)

Aboriginal and Islander Community Health Service Brisbane, Aboriginal and Torres Strait Islander Community Health Service Mackay, Apunipima Cape York HC, Barambah Regional Medical Service, Bidgerdii Community Health, Bundaberg Indigenous Wellbeing Centre, Carbal Medical Centre, Charleville and Western Areas Aboriginal and Torres Strait Islander Corporation for Health, Cunnamulla Aboriginal Corporation for Health, Galangoor Duwalami Primary Health Care Service, Girudala Community Co-operative, Goolburri Health Advancement, Aboriginal Corporation, Goondir Health Service, Gurriny Yealamucka Health Service, Injilinji Youth Health Service, Kalwun Health Service, Kambu Medical Centre Mamu Health Service, Mount Isa Aboriginal Community Controlled Health Organisation, Mudth Niyleta Aboriginal and Torres Strait Islander Corporation Mulungu Aboriginal Corporation Medical Centre, Nhulundu Wooribah Indigenous Health Organisation, North Coast Aboriginal Corporation for Community Health, Townsville Aboriginal and Islanders Health Services, Wuchopperan Health Service , Yulu Burri-Ba Aboriginal Corporation for Community Health.

NACCHO WA BOARD REPS

Phillip Matsumoto
Lorraine Whitby

WA MEMBERS
(AS ADVISED BY ACHWA)

Beagle Bay Community HS, Bega Garnbirringu HS, Bidyandanga ACHS, Broome Regional AMS, Carnarvon AMS, Derbarl Yerrigan HS, Derby AHS, Geraldton Regional AMS, Jurrugk Health Service, Kimberley AMSC, Mawarnkarra HS, Ngaanatjarra AHS, Nindilingarri Cultural HS, Ord Valley AHS, Puntukurnu AMS, South West AMS, Wiluna AMS. Wirraka Maya AMS, Yura Yungi AHS.

NACCHO VIC BOARD REPS

AndrewGardiner
Lyn McGuiness

VIC MEMBERS
(AS ADVISED BY VACCHO)

Central Gippsland AHHC, Moogji AC, Lake Tyers H&CS, Gippsland and East Gippsland AC, Gunditjmara AC, Ramahyuck District AC, Wathaurong AC, Bunurong HS, Victorian AHS, Rumbalara AC, Mungabareena AC, Murray Valley AC, Mildura AC, Kirrae CHS, Ballarat and District AC, Goolum Goolum Co-op, Dja Dja Wrung AC, Ngwala Wilumbong, Njernda AC, Winda Mara AC, Dhau Wurd-Wurrung Elderley CA, Budja Budja AC, Bendigo District A.C, Aboriginal Community Elders Service, Western Suburbs Indigenous Gathering Place Assoc.

NACCHO SA BOARD REPS

Yvonne Buza
John Singer

SA MEMBERS
(AS ADVISED BY AHCSA)

Nunkuwarrin Yunti of SA Inc, Tullawon HS, Aboriginal Sobriety Group, Oak Valley HS, Port Lincoln AHS, Nganampa Health Council, Umoona Tjutajku HS, Kalparrin Community, Kainggi Yuntuwarrin AHS, Ceduna Kooniba AHS, Pika Wiya AHS, Pangula Mannamurra, Wakefield AHAC, Hills Mallee Southern AHAC, Mid North AHAC, Riverland AHAC, South East AHAC, Eyre AHAC, Northern AHAC.

NACCHO NT BOARD REPS

Stephanie Bell
Paula Arnol

NT MEMBERS
(AS ADVISED BY AMSANT)

Ampilatwatja HC, Anyinginyi Health AC, Central Australian Aboriginal Congress, Mutitjulu HS, Danila Dilba AHS, Sunrise AHS, Urapuntja HS, Wurli Wurlinjang AHS, Pintubi Homelands AHS, Miwatj AHC, Katherine West HB, Imanpa HS, Congress Alukura.

NACCHO TAS BOARD REP

Raylene Foster

TAS MEMBER

Tasmania Aboriginal Corporation

NACCHO ACT BOARD REP

Julie Tongs

ACT MEMBER

Winnunga Nimmityjah AHS

NACCHO NSW BOARD REPS

Christine Corby
Val Keed

NSW MEMBER
(AS ADVISED BY AHMRC)

AMS Redfern, Pat Dixon Medical Centre, Biripi AMS, Brungle AHS, Albury /Wodonga AHS, Awabakal AMS, Balranald AHS, Bourke AMS, Amarjun AHS, Brewarrina AMS, Bulgarr Ngaru AC, Cobar AHS, Condoblin AHS, Coomealla AHC, Coonamble AHS, Cumbo-Gunerah AHS, Cummeragunja H&DAC, Daruk AMS, Dharah Gibinj AMS, Dhoongang AHS, Durri AMS, Euraba Mungindi AHS, Galambila AHS, Griffith AMS, Illawarra AMS, Katungal AMS, Menindee AHS, Murrin Bridge AHS, Nambucca Valley AHS, Ngambra AHS, Orange AHS, Parkes AHS, Peak Hill AMS, Pius X AC, Riverina M&DHAC, South Coast AMS, Tamworth AHS, Tharawal AC, Thubbo AMS, Tobwabba AMS, Toomelah AHS, Wallhallow AC, Walgett AMS, Wanaruah AHS, Weimija AC, Wellington ACHS, Yoorana-Gunja Family Violence Healing Centre, Yerrin AHS.

Chief Executive Officer's Report

In my last report I reflected on how changes to the political landscape occurred. There was an environment of cooperation and partnership, and the single largest direct financial investment to address Aboriginal health inequality. This led to a year of expectation and opportunities that NACCHO's policy initiatives, lobbying efforts and partnership building hopefully placed the Sector advantageously towards achieving real outcomes. The Aboriginal Community Controlled Health Sector (ACCHS) expected, and indeed received, many challenges but it also had hope. Hope that our years in the policy wilderness were over and that engagement with government and key-stakeholders had the potential to provide our Sector with more control over the primary health care delivery in our communities.

Whilst previous years were challenging and complex this year was extremely hectic. Broadly speaking NACCHO's level of work increased exponentially as our focus turned towards assisting the Commonwealth with the implementation of the COAG measures. Partnerships were also tested, as more funds were released to support mainstream services to be more responsive to our Peoples health needs. With the ever escalating demands for NACCHO to sit on a myriad of committees, mounting pressure for complex technical advice and review, mounting demands to respond to rapid changes in the health system together with juggling our own core activities and expansion. Underpinning all of our responses was our continued focus upon our Sectors core message to government regarding the current CTG measures – that the measures will not close the life expectancy gap within a generation for Aboriginal Peoples, as we were not involved in the design of the measures from the outset.

It is not possible for me to give justice to the full range of activities that the Secretariat undertook this year. These are reported later in this Annual Report. Therefore, I have chosen a few specific areas to highlight the depth and breath of our achievements and challenges. But first, due to the changes in Board leadership at the last AGM, I would like to thank and recognise the contributions of the outgoing NACCHO Chairperson, Dr Mick Adams for his hard work and commitment. Dr Adams' dedication and knowledge of men's health issues assisted in focusing greater attention upon the health issues facing Aboriginal men, in particular the strengthening of our response to Aboriginal Men's health through various forums and initiating the development of a policy statement on Aboriginal Male Health. In addition, his implementation of comprehensive governance training to refresh existing and up skilling new Board Members is significant as it assisted in delineating the roles and responsibilities between NACCHO Board Members and Secretariat Staff.

NACCHO also welcomes the incoming Chairperson, Justin Mohamed. His experience and contribution to the Sector is well documented but in particular his ability to liaise with government ministers and officials, his time commitment and contribution to a range of committees such as the CTG Steering Committee has greatly assisted in achieving significant outcomes for our Sector.

I have raised the complexity and changing landscape of Aboriginal health through the COAG measures. These measures are complex, particularly where they intersect with Close The Gap and the Health and Hospital Reform agenda. The reform process of the Australian health care system is subject to intense scrutiny and this year marked one of the most fundamental and rapid changes in the Australian health care system with the release of three major reform papers. They are as follows:

- *National Health and Hospitals Reform Commission (NHHRC) Report;*
- Primary Health Care Strategy, *Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy;* and
- Primary Health Care Reform in Australia, *Australia – the healthiest Country by 2020 – National Preventative Health Strategy.*

All of these reports intersect and through the COAG agenda and public consultation, various recommendations are being actioned. This has often required the Secretariat to reprioritise its actions and respond to the swift and complex changes within the health arena.

The specific challenges for the Sector were: our response to these overarching reforms; the rapidity, complexity and changes in the reform process; ensuring adequate consultation and communication with Members; retaining focus and attention on Aboriginal health; guard against incorporation into mainstream health and ensuring placement of funds appropriately within the Sector. NACCHO has responded in a variety of manners involving forums, formal submissions to government, assisting Member's responses and developing position statements.

Workforce also remains an important element of NACCHO's work at the national level with the introduction of the COAG Workforce Expansion Measures, the employment of a national COAG Project Officer, and the award Modernisation process, whereby NACCHO achieved a national Award which recognises the uniqueness of our Sector as an industry within the Australian health system. In respect to the Aboriginal and Torres Strait Islander Outreach Workers (IOWs), NACCHO received funds from the Mental Health and Workforce branch of the Department of Health and Ageing to conduct jurisdictional workshops to develop an orientation package for the IOWs.

Outcomes in other areas relate to the success of the QUMAX program with all QUMAX services now signed up for the COAG Indigenous Practice Incentive Payments (PIP) and the Pharmaceutical Benefits Scheme (PBS) Co-Payments measures. Serious concerns remain around data collection and registration processes whilst services become more certain of the extension of QUMAX to the end of this financial year. The national QUMAX conference in Melbourne (March 2010) assisted in communicating the elements of the program and its extension through to the new COAG PIP and PBS Co-Payments.

The NACCHO Communication Network is in operation and is assisting the streamlining and co-ordination of programs within the Sector to improve communication and sharing of resources related to all programs. In particular, this includes specific program areas such as QUMAX; Public Health Officers Network; Workforce; Information Communication

Technology/Information Management Network (ICT/IM); Accreditation Network and support and a cultural safety training inventory to provide information to pharmacies (and other interested health professionals) regarding cultural training opportunities.

NACCHO continues to be involved in research at all levels. One research project NACCHO is directly involved with is in collaboration with the National Centre in HIV Epidemiology and Clinical research (NCHECR) and five of our Member Services. Site visits have commenced to these services to build relationships between our services, NCHECR and NACCHO. The focus is upon Hepatitis C management and screening for the STIs, in particular Chlamydia. NACCHO's Memorandum of Understanding (MoU) with NCHECR has also been extended. In other areas NACCHO's Sexual Health and Blood Borne Virus Advisory Committee continues its work and the activities of these areas are reported more fully in this report.

The strong emphasis on domestic politics has also been supplemented by a focus upon International activities with the visit to Australia by the United Nation's Special Rapporteur *on the situation of human rights and fundamental freedoms of Indigenous Peoples,* Professor James Anaya. Professor Anaya's report once again highlighted the lack of Australian government commitments to allow our Peoples to be involved in the design of policies and programs that impact on our communities towards improving health outcomes for Aboriginal Australians. NACCHO once again had a presence at the United Nations 9th Permanent Session on Indigenous Affairs. This work is important, as it appears to be one of the few forums through which government commitments can be measured against activities.

Finally, I would like to thank the NACCHO Board of Directors, the CEO Network, Affiliates and Members for their support and constructive assistance. Again you have all risen to the challenge and taken forward a range of matters and in doing so have assisted NACCHO to achieve remarkable outcomes this year. Once again, the staff at the Secretariat have worked tirelessly to meet not only NACCHO's core commitments, strategic targets and action priority areas for our Members, but have also addressed the ever evolving, complex and rapid changes in health.

As a Sector we have much more challenging work to progress. At times this work feels unappreciated but what sustains me, and I suspect the majority of people that work in our Sector, is an overwhelming and unshakeable belief that we are slowly but surely making a difference. A difference in the lives of individuals and communities; to slowly changing the attitudes of the Australian population towards greater tolerance and acceptance of our right of self-determination, and a realisation by mainstream health providers that we are highly skilled and essential to any real outcomes for Aboriginal Peoples. The simple reality is, that if the programs designed to address inequality in Aboriginal health are not designed, driven and implemented by the very people they affect, they will simply, not work.

Dea Delaney Thiele
Chief Executive Officer

REPORTING ON STRATEGIC PRIORITIES: PROVIDE LEADERSHIP AND DIRECTION IN POLICY DEVELOPMENT

NACCHO has been particularly busy this year advocating for Aboriginal health and representing the interests of our members to maximise our opportunities to influence the Australian Government as its health reform proposals take shape.

National Partnership Agreement

NACCHO has worked with the Minister for Indigenous Health, The Hon. Warren Snowdon in developing a joint statement between the Australian Government and NACCHO. This Statement outlines the commitment to working collaboratively to Close the Gap in health equality between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians. NACCHO is keen to progress this Statement to enable a closer and equitable relationship with government in order to assist in developing more appropriate health policy for Aboriginal peoples.

Indigenous Chronic Disease Package (ICDP)

This program was announced in November 2008 as part of the Council of Australian Governments (COAG) $1.6 billion dollar commitment to Close the Gap in Aboriginal people's life expectancy. There are 14 measures within the ICD package and NACCHO has worked with the Department of Health and Ageing (DOHA) across all of these measures, including informing and liaising with Affiliates and member services throughout Australia (Table 1).

NACCHO's objective has been to ensure the programs that result from the COAG commitments are in large part realised through the Aboriginal Community Controlled Health Services (ACCHSs), as they are critical to Closing the Gap in Aboriginal disadvantage. These efforts have increased the Secretariat workload considerably, but the renewed relationships established between NACCHO and the Department have been welcomed.

A number of Technical Reference Groups with NACCHO representation have been established for the ICDP and these are summarised on page 24 of this layout. This section describes NACCHO activity with regard to many of the ICDP measures (Table 1).

Table 1. Indigenous Chronic Disease Package (ICDP): Commonwealth

Priority Area	Measures	What does it really mean?	4 year funding $ million
Preventing chronic disease	National Action to Reduce Indigenous Smoking Rates	Regional Tobacco Coordinators, Tobacco Action Workers and training measures / activities	$100.6
	Helping Indigenous Australians Reduce Their Risk of Chronic Disease	Healthy Lifestyle Workers, etc	$37.5
	Local Indigenous Community Campaigns to Promote Better Health	Tobacco social marketing, etc	$22.7
Primary health care services that can deliver	Subsidising PBS Medicine Co-payments	Establish the PBS co-pay relief scheme	$88.7
	Higher Utilisation Costs for MBS and PBS	To fund the PBS and PIP reforms	$140.5
	Supporting Primary Care Providers to Coordinate Chronic Disease Management	To establish the Indigenous PIP, and the Care Coordination and Supplementary Services program (CCSS)	$115.1
	Improving Indigenous Participation in Health Care through Chronic Disease Self Management	Linked with Healthy Lifestyle Workers, chronic disease self-management programs	$18.6
	Increasing Access to Specialist and Multidisciplinary Team Care	Medical Specialists Outreach Assistance Program (MSOAP-ICD) and Urban Specialist Access Program, etc	$70.8
	Monitoring and Evaluation	Urbis Pty Ltd Monitoring and Evaluation Framework, Menzies School of Health Research with Sentinel sites, Australian Institute of Health and Welfare (AIHW), web-based reporting tool, etc.	$39.9
Fixing the gaps and improving the patients journey	Workforce Support, Education and Training	Indigenous Outreach Workers (IOWs), training, etc	$17.7
	Expanding the Outreach and Service Capacity of Indigenous Health Organisations	80 IOWs employed within ACCHSs, Practice Managers, minor housing clinic upgrades, Project Officers within NACCHO Affiliates, etc	$68.4
	Engaging Divisions of General Practice to Improve Indigenous Access to Mainstream Primary Care	80 IOWs employed within Divisions network, 80 FTE Project Officers within Divisions, including state-based organisations and AGPN.	$75
	Attracting More People to Work in Indigenous Health	Market research	$7.2
	Clinical Practice and Decision Support Guidelines	Development of a 'primary care resource' and guidelines.	$3.1
	Total Funding For Measures		**$805.5**

Ref: Modified from: The Australian Government Indigenous Chronic Disease Package.

Indigenous Practice Incentive Payment (PIP)

The new Indigenous PIP commenced in May 2010 as a blended payment to general practices and ACCHSs to supplement funding for primary health care for registered chronic disease patients 15 years of age and over. Payments are made to register Aboriginal or Torres Strait Islander patients, with additional reward payments to those services that produce specified outcomes. ACCHSs that are not PIP eligible will not be able to claim any funds from this measure. Only practices that are accredited to Royal Australian College of General Practitioners (RACGP) standards are eligible for these payments.

Practice Incentive Payments have been paid for a range of health issues, but this is the first time financial incentives are being paid to practices to take care of patients who identify as being Aboriginal or Torres Strait Islander. Some $298 million was paid to General Practices and GPs under the PIP in 2008–09.[1] The Indigenous PIP was developed and introduced despite an absence of evidence that the PIP stimulates the delivery of better health outcomes.[2]

By working closely with the DOHA, NACCHO has immeasurably influenced the Indigenous PIP. The NACCHO Secretariat prepared an Issues Paper in June 2009, which informed the Technical Reference Group proceedings and led to modifications to the PIP. Briefings were provided to Affiliates and their members in August 2009 (subject to DOHA's confidentiality restraints), and an article in the Medical Journal of Australia published in December 2009.[2] A NACCHO survey, undertaken with the support of Affiliates, was reported to the Board in August 2009. The survey results showed one third of all ACCHSs are not enrolled in PIP. However, most unenrolled ACCHS are eligible to apply, although many will be 'locked out' because they require capital works or are unable to employ a GP.

NACCHO argued for mainstream general practices signing up to the Indigenous PIP be required to undertake some form of cultural safety training (CST) or awareness training within 12 months, and provided a joint position statement on this matter in partnership with the RACGP. NACCHO advised the DOHA to exclude the requirement for CST if Services are governed by an Aboriginal Board of Directors or a committee comprised of Aboriginal community representatives. The need to coordinate CST for mainstream general practices and to establish national standards for such training became apparent and NACCHO has taken the lead in progressing a body of work for the development of such standards (see CST section).

These and other modifications to the PIP Guidelines, patient registration and consent forms, plus many other aspects of the measure advised by NACCHO, were accepted and now form the requirements for the program. NACCHO also provided technical advice regarding the evaluation of the Indigenous PIP.

1 In accordance with the *Auditor-General Act 1997*, the Commonwealth Auditor-General has designated a performance audit of the PIP due to be released in late 2010. Australian National Audit Office. Audit Work Program, July 2010. http://www.anao.gov.au/awp2010/index.html

2 Couzos S, Thiele D. *The new "Indigenous health" incentive payment: issues and challenges.* MJA 2010;192:1-4.

PBS Co-Pay Relief Measure

As of the 1st June 2010, financial assistance is being provided to Aboriginal patients to improve their access to PBS medicines by alleviating or removing the cost of co-payments (courtesy of the ICDP). This measure provides a waiver of the co-payment fee for concessional patients (free PBS medicines from an annotated script) and a reduced co-payment for non-concessional patients.

This measure applies to those patients attending private general practices and 'Indigenous health services' in non-remote areas. Unlike the Indigenous PIP, all non-remote ACCHSs are eligible for co-payment relief of their patients (not just accredited ACCHS).

The PBS Co-pay measure is an uncapped medicines access program, making it similar to the section 100 scheme, for all Aboriginal people of any age (means testing not required) with an existing chronic disease or who are 'at risk of chronic disease', and who are most in need. However, the co-payment measure has no quality use of medicines support, no support for Dose Administration Aids (DAA) and other elements that make the Quality Use of Medicines Maximised for Aboriginal peoples and Torres Strait Islanders (QUMAX) program so successful. In order to provide these elements, the Australian Government has extended QUMAX funding for another four years through the 5th Community Pharmacy Agreement (*see QUMAX section*).

NACCHO shaped the co-pay relief program. First, it stimulated its development by showing that medicines access can be improved if co-payment relief is provided to Aboriginal peoples (through QUMAX developed by NACCHO and the Guild over 2005–2007):

> *"The program will build on a trial currently being conducted under the Fourth Agreement, Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples [QUMAX] ... and information from the evaluation will help in the design of the PBS component of the National Partnership initiative."*[3]

> *"If we didn't have QUMAX, we wouldn't have this. This is a big win for NACCHO."*[4]

Second, NACCHO assisted in shaping the measure through membership of the Technical Reference Group and by referencing the success and experiences of QUMAX. This included:

- Ways to foster partnerships with community pharmacies;
- Guidelines to ensure that the most needy Aboriginal patients benefit;
- Defining the impact on different types of services providers in remote and non-remote areas;
- Amending the DOHA definition of 'Indigenous health services';
- Modelling practitioner behaviour;
- Defining what is meant by 'at risk of chronic disease'; and
- Supporting software improvements to enable script annotation.

NACCHO also provided technical advice regarding the evaluation of this measure (*see ICDP Implementation and Evaluation and Monitoring Framework*).

[3] Federal Budget Portfolio Statement Outcome 2: Access to Pharmaceutical Services, 2009. Page 105.

[4] PBS co-pay relief program, Lesley Podesta, FAS, OATSIH, NACCHO Board meeting, 17 March 2009.

Care Coordination and Supplementary Services (CCSS)

The NACCHO Secretariat appraised this program twice providing detailed submissions to the DOHA on both occasions.[5] The core feature of the program involves State Based Organisations (SBO) of the GP Divisions Network being fund-holders for the care of Aboriginal patients with chronic disease, and managing 'care coordination' activity by employing 'care coordinators'. The program is only available to PIP registered practices.

In its submissions, NACCHO expressed serious doubts that this approach would be an effective use of taxpayers' funding. Contrary to expectations, a GP within a mainstream practice is effectively encouraged to 'refer' any difficult or complex Aboriginal patients to an external agent to conduct all the caring and planning.

Funding to SBOs would be based on the total Aboriginal population in that state or territory and assumes all Aboriginal patients attended mainstream health services.

In the absence of any evidence as to the prior effectiveness of this approach combined with the robust evidence that SBOs/Divisions have not been effective in providing services to Aboriginal peoples, NACCHO recommended the development of a separate program specifically for patients attending ACCHSs. DOHA was encouraged to engage directly with the Affiliates for the development of a CCSS measure for their patients rather than funding an intermediary (SBOs), and requiring more contracts with ACCHSs. These recommendations were not adopted.

SBOs will be required to 'consider' service delivery principles of 'engagement, access and accountability'. None of these principles have yet been operationalised in a manner which is open to scrutiny and agreement from Aboriginal communities and their representative bodies. In effect, SBOs can interpret these 'principles' as they wish without a framework to assess compliance. NACCHO argued that this was a highly arbitrary manner in which to secure valid outcomes from taxpayers' dollars to close the gap in Aboriginal disadvantage.

COAG Workforce Initiatives

The COAG health funds to Close the Gap in Aboriginal and Torres Strait Islander health disadvantage included $171 million to increase the capacity of the frontline primary care workforce to care for Aboriginal and Torres Strait Islander peoples with chronic diseases. This included the rollout of new positions in each State and Territory for Aboriginal and Torres Strait Islander Outreach Workers, Tobacco Action Workers and Healthy Lifestyle Workers.

NACCHO successfully lobbied for the title Indigenous Outreach Worker (IOW) to be changed to Aboriginal and Torres Strait Islander Outreach Worker (ATSIOW).

The Aboriginal and Torres Strait Islander Health Registered Training Organisations National Network, (ATSIHRTONN) was funded by the Indigenous Health Workforce Section of the

[5] NACCHO Response To The Discussion Paper: Closing The Gap: Care Coordination And Supplementary Services (CCSS), NACCHO, October 2009.

Department of Health and Ageing (DOHA) to conduct a needs analysis on the orientation, education and training of the new and existing Aboriginal health workforce.

From April-June 2010, NACCHO in collaboration with the DOHA conducted a series of jurisdictional workshops across Australia with the aim of informing ACCHSs of the COAG Workforce and Training Measures.

These workshops assisted States and Territories with their jurisdictional orientation and training needs through the strengthening of flexible delivery modes for orientation and training to the relevant areas of workforce need.

The workshops brought together key stakeholders to discuss existing mechanisms and tools to identify orientation and training needs for the new workforce positions under the Indigenous Chronic Disease Package'.

Each Jurisdiction worked toward the development of suitable orientation packages through the identification of existing modules and orientation and training materials as well as key Registered Training Organisations (RTOs) who may be able to assist with flexible delivery.

Jurisdictional reports were finalized and collated into a National Report which will inform the next steps in accredited training development and orientation for the new COAG workforce.

Tackling Tobacco measure

NACCHO provided substantial input into the Tackling Tobacco measure through technical appraisal and advice on social marketing provided by nominees from NACCHO Affiliates. NACCHO also provided technical advice regarding the evaluation of this measure (see ICDP Implementation and Evaluation and Monitoring Framework).

Medical Specialists Outreach Assistance

There are two main specialists packages under the Medical Specialist Outreach Assistance program. One of the measures is the Urban Specialist Outreach Care program intended to improve access to medical specialist care for Aboriginal peoples with a chronic disease located in urban settings. The objectives of the program for Aboriginal peoples are to:

- Assist to establish new and expand existing medical specialist outreach services in urban areas;
- Expand services in primary care settings that are culturally sensitive to the needs of Aboriginal and Torres Strait Islander people; and
- Focus primarily on management and treatment of chronic disease.

NACCHO provided a submission to DOHA on the draft Guidelines of this program on January 2010 which included contributions from Affiliates.

The other measure is the Medical Specialists Outreach Access Program-Indigenous Chronic Disease (MSOAP-ICD) measure for rural and remote areas (also a component of the

November 2008 COAG package). The DOHA released the final version of the MSOAP-ICD Guidelines for this program on 30 November 2009. Unlike the Urban Specialists program, this measure expands the mainstream MSOAP program to include specialist and allied health services to Aboriginal communities. NACCHO provided a submission to DOHA prior to the finalisation of the Guidelines.

Unlike the 'Indigenous PIP' which permits GPs and staff 12 months to undertake training, specialists and allied health professionals *"must demonstrate that they have undertaken appropriate cultural awareness and safety training prior to commencing service delivery"*.[6] This illustrates the inconsistency in the approach to cultural training promoted by the DOHA.

Of concern, the Guidelines no longer require Aboriginal Medical Services (AMSs) and community health centres to be the primary place of service delivery The removal of this requirement was to 'open up' mainstream health services as sites of specialist service delivery to Aboriginal peoples as other stakeholders had advocated for this approach. For example, the submission from the Royal Australian College of Physicians (to the MSOAP-ICD guidelines, Nov 2009) stated:

> *"... the College wishes to impress that local mainstream medical services should be able to support MSOAP ICD services. Indigenous patients present at AMSs, community and mainstream services."*

NACCHO alerted the DOHA that this initiative is about access to care and ACCHSs are the primary vehicle established by Aboriginal peoples themselves to address that lack of access. This understanding has been endorsed by the Northern Territory Health Forum and in Victoria through their COAG implementation plans, which the MSOAP-ICD Guidelines now appear to undermine.

NACCHO is keen to be informed of any concerns members have with this measure as it is rolled out. Importantly, there has never been an evaluation of the MSOAP since it was established in 2000. In the absence of an evaluation (and its impact on Aboriginal peoples to date), it is difficult to assess how effective the MSOAP-ICD measure might be for Aboriginal peoples.

Chronic Disease Package Implementation, Evaluation and Monitoring Framework

The *COAG National Indigenous Reform Agreement (2009)*[7] requires that:

> "the Commonwealth and the State and Territory Governments commit to working in partnership with Indigenous people ...[to] do this through *the use of existing frameworks or mechanisms for engagement* established in each state or territory, and *by sharing* with Aboriginal and Torres Strait Islander people *information on performance against indicators* in implementation plans and agreements, and reports on progress towards the COAG targets."

[6] Page 7 MSOAP-ICD Guidelines.

[7] This Agreement implements intergovernmental reforms to close the gap in Indigenous disadvantage.

It is difficult to see how this commitment might take effect given there is no framework or agreement to guide a partnership or to share nationally collected information with our sector. NACCHO continues to promote the development of a national Information Agreement. In the absence of such a commitment, NACCHO is solely reliant on the good will of individuals across the DOHA, a risky strategy unlikely to foster a sustainable partnership.

On 22 September 2009, the OATSIH released the COAG Australian Government Implementation Plan for the ICDP, a requirement of the COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes. Although the Plan was not released for public consultation, NACCHO immediately provided a written response, particularly remarking on the failure to monitor the performance of mainstream health services that are in receipt of the bulk of the ICDP monies.

In December 2009, the DOHA announced Urbis Pty Ltd as the winning tender to develop the Monitoring Framework for the ICDP package. Urbis Pty Ltd has also engaged the Menzies School of Health Research and the Cooperative Research Centre for Aboriginal Health (CRCAH) to join them in this work.

NACCHO met with Urbis regarding this Framework (3rd February 2010) and raised three core issues:

- The need for the Framework to be built around a core objective. How valid were the elements of the $806m package towards closing the gap in health equality? How valid are the Australian Governments assumptions that providing greater funding to general practice will close the gap?
- Avoid burdening ACCHSs in this evaluation. No new indicators should be added to ACCHSs reporting function for the purpose of the COAG evaluation.
- Monitor the performance of mainstream practices. As it is common for Divisions of General Practice (GP) to claim outcomes when they are really the activity of ACCHSs, it is vital for the framework to disaggregate outputs by 'service type' for measures targeted mostly towards mainstream health services (i.e. GPs and Divisions). New indicators should be developed for general practices, so that the reporting burden is consistent with the direction of investment.

These matters were also raised through the three NACCHO representatives on the ICDP Monitoring and Evaluation Reference Group. A detailed submission was prepared by NACCHO on the draft framework in June 2010. At a meeting with DOHA to discuss the content of this submission it was agreed that the advice prepared by NACCHO would be considered and a detailed Departmental response to the matters raised by NACCHO's submission prepared in response. This is still pending.

Sentinel Sites

A part of the monitoring and evaluation component of the Commonwealth's ICDP is the establishment and management of 32 'sentinel sites', which are geographical regions made

up of general practices, Divisions of GP, and 'Indigenous health services'. (RFT 19 October 2009). The Menzies School of Health Research was commissioned to undertake the evaluation.

NACCHO has provided information to Affiliates and monitored this work through the above-mentioned Reference Group. The main issues raised by NACCHO pertain to ensuring that the research complies with ethical obligations, ensuring adequate consultation with the sector, developing an agreement over data management, ensuring mainstream general practices are not under-evaluated and correspondingly ACCHSs are not over-evaluated, and ensuring transparency in the proposed project. However, NACCHO has had a limited response from DOHA and Menzies regarding these queries.

National Performance Indicators

The COAG *National Indigenous Reform Agreement* (2009)[8] committed to the following:

> "The Commonwealth Department of Health and Ageing, in partnership with State and Territory health departments and in collaboration with AIHW (Australian Institute of Health and Welfare), will develop *national Key Performance Indicators (national KPIs) for Indigenous-specific primary health care services*..... It is intended that a web based reporting system will be progressively developed and provided to Indigenous primary health care services to collect data associated with the national KPI framework."

It is unclear why the Reform Agreement did not recommend performance indicators for general practices to monitor their progress in closing the gap (as most ICDP funding is through mainstream general practices). ACCHSs, yet again, appear to be the 'easy target' for data collection pertaining to Aboriginal people's health.

At the Broome NACCHO Members meeting, November 2008, the members recommended that NACCHO customise the NT/QLD Performance Indicators.

To this end, NACCHO has been coordinating the development of a national set of Key Performance Indicators (KPI) for the ACCHS sector. Discussions between NACCHO and OATSIH have confirmed that a proposed set of national KPIs (nKPIs) will act as a quality assurance initiative for services as part of continuing quality improvement activities.

NACCHO work on National Key Performance Indicators (nKPIs)

Throughout this period NACCHO held meetings with OATSIH for joint nKPI planning and initiated discussions with Affiliates. NACCHO developed *a KPI comparative Matrix* using the Queensland Aboriginal and Islander Health Council (QAIHC) and NT Health Forum KPIs in order to progress a nKPI set. The Matrix was provided to OATSIH for their use.

[8] Page F-83.

Some jurisdictions have developed strategies for the management of data collected from ACCHSs. For example, the NT Health Forum Partners are signatories to a 'Data Management Strategy and Protocols' which provide a useful template to adapt into a national governance protocol for national KPIs. It states:

> The objective of this [Data Management Strategy and Protocols] document is to define a Data Management Strategy that covers the protocols for data receiving, privacy, release and an overarching governance structure that provides Aboriginal Health National Key Performance Indicators (nKPI) participating services assurance that their data will be:
>
> - Protected from unauthorised use; and
> - Provided under a strict and consistent protocol.

Based on those indicators developed by QAIHC and the Aboriginal Medical Services Alliance Northern Territory (AMSANT), the NACCHO Secretariat hosted a workshop in November 2009, with Affiliate CEOs (and their public health officers) to progress the development of nKPIs for ACCHSs. The agenda sought to technically appraise a potential set of indicators which could be used by members for quality improvement. NACCHO and OATSIH prepared for the workshop in great detail and it was understood that that some quality assurance indicators could be useful as a by-product to inform progress with COAG measures.

NACCHO understands that subsequently OATSIH has advanced the development of indicators with each State/Territory directly but have asked the AIHW to develop nKPIs for ACCHSs. No reply has been received to date from OATSIH regarding data management protocols nor on the need to support the sector to develop its own national quality assurance performance framework.

Data Rationalisation

In July 2009, the OATSIH released a Stakeholder Feedback Report regarding data rationalisation from ACCHSs. This Report contained recommendations which NACCHO did not believe represented a mandate from the ACCHS sector as services outside the sector were included in the feedback.

A subsequent NACCHO submission was prepared (August 2009), which outlined these concerns. In particular, the Stakeholder Feedback Report stated:

> "There was acceptance of the AIHW being the appropriate body for data collection, analysis and reporting with recognition of the National Aboriginal and Torres Strait Islander Health Data Principles *with some degree of Aboriginal oversight*...service providers looking to the AIHW for support around interpretation of information and business focused analysis, saw this as a 'return on investment' for the AIHW assuming the role of national data custodian." P2.

NACCHO believes it is not the role of the AIHW to interpret ACCHSs data. The dissolution of the Service Activity Reporting (SAR) and the SAR Steering Committee (and the Information

Agreement that protects our members' data) to be replaced by the AIHW as data custodian of all ACCHSs is not what NACCHO recommended.

Given that the DOHA have designated the AIHW as the custodian of all data from ACCHSs, NACCHO recommended OATSIH recognise that ACCHSs own this data even when nationally aggregated. A national governance framework for the activity of the AIHW in this regard was recommended by NACCHO. OATSIH have to date not responded positively to this recommendation.

Health services utilisation data

The matter of flawed health services utilisation data[9] was raised with the National Advisory Group on Aboriginal and Torres Strait Islander Health Data (NAGATSIHD) July 2009. It was also raised with the Productivity Commission in July 2009 regarding the *Overcoming Indigenous Disadvantage: Key Indicators 2009 Report*. NACCHO asked the Productivity Commission to correct their use of discredited data which elicits an incorrect picture of ACCHSs use in Australia. On this matter, NACCHO had another letter published in the Medical Journal of Australia (November 2009).[10]

Healthy for Life

The evaluation of the *Healthy for Life* Program by Urbis Pty Ltd was completed and released on 8 January 2010 by DOHA uploading the report on the Government's website. These findings were used to brief the NACCHO Board because this program positioned the AIHW as the national data custodian for all ACCHSs, and the demise of the SAR Information Agreement between NACCHO and DOHA. Urbis wrote:

> "In addition to the problem of incomplete information being available to services at the time of application, another limitation identified by some stakeholders within the ACCHSs sector is the missed opportunity to engage the Affiliates as part of the communication and support network for services." (p 14)

Healthy for Life excluded Affiliates from building the quality improvement capacity of the sector despite OATSIH acknowledging this is the Affiliates core responsibility. *Healthy for Life* funding is now part of ongoing core grants to participating services.

Aboriginal Health Data Principles

In January 2010, NACCHO provided a submission to the AIHW reviewing the implementation of the National Aboriginal and Torres Strait Islander Health Data Principles endorsed by AHMAC in 2006. The Review was "to identify the extent to which the Data

[9] Flawed data was quoted by the Prime Minister, Mr. K Rudd in relation to the COAG Close the Gap initiative. Referring to the Report *Closing the gap on Indigenous disadvantage: the challenge for Australia* he addressed parliament and asserted that government strategy to close the gap would focus on the treatment of Indigenous Australians' illnesses "largely through the mainstream health system, because that is where 70% of Indigenous people are treated". Ref: MJA, 2009 190:10:541.

[10] Couzos S, Thiele D. *Close the Gap: Ask the experts*. MJA 2009 191:10: 583.

Principles have had a positive impact on the practice of data collection and governance bodies and will also identify the extent and nature of any issues encountered while implementing the guidelines." The issues raised by NACCHO were:

1) The lack of 'guidelines' or 'explanatory guide' to assist with the implementation of the Data Principles as this fosters variable interpretation. This matter was first raised by NACCHO in its submission to OATSIH in December 2008 regarding the Review of Reporting Requirements.
2) Departmental misunderstanding as to the role of the Data Principles were they were never meant to supersede the NACCHO-OATSIH Information Agreement on nationally aggregated data. OATSIH's view was that:

> "Indigenous health data collection should abide by the National Aboriginal and Torres Strait Islander Health Data Principles, agreed by AHMAC on 26 October 2006. **This supersedes the Information Agreement and negates the need for any new bipartite Information Agreement."**[11]

When NACCHO and Affiliates endorsed the Data Principles, they did not endorse that the NACCHO-OATSIH Information Agreement be superseded. NACCHO was involved in the development of these Principles over a period of many years. It has always been the intent that these Principles contain explanatory notes to avoid misinterpretation.

To assist this and other work, NACCHO developed a *National Policy Statement on Rationalised Reporting Requirements (for National Aboriginal Health Information and Data Collection)* in October 2009.

OATSIH Web-Based Reporting Tool

OATSIH is building an online web-based reporting tool for organisations and departments incorporating reporting requirements, health statistics and outcomes.

The policy drivers for this project are the review of the Department's reporting requirements and the implementation of a new reporting framework. The project is funded by the Australian Government as an element of the Monitoring and Evaluation (B6) measure of the 2009 Budget *Indigenous Chronic Disease Package*. The package is designed to monitor and evaluate the Commonwealth's contribution to the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes.*

The vision for the Web–Based Reporting Tool being promoted by OATSIH is as follows:

- A single, fast, reliable and efficient vehicle for service data;
- Secure transmission and management of- and access to- service data;
- Replacement of separate web-based and paper-based collection processes;
- Minimal manual data entry for health services;

[11] Senate Estimates, June 2008, page 54.

- Health service providers empowered to monitor and improve their data quality;
- Health service providers access summary reports on client and service outcomes; and
- National KPI data collected from OATSIH funded and State/Territory-funded Indigenous-specific health services.

NACCHO and Affiliates held a number of consultations and presentations with OATSIH on matters relating to the process, purpose, access and ownership of information. These discussions also included the issue of governance arrangements and the need for Business Rules.

Return of Data to Aboriginal Communities Project

In March 2010 NACCHO entered an Agreement with the Australian Institute of Health and Welfare (AIHW) to fully understand and explore the many factors relating to the collection, ownership, storage, security, access, release, usage, reporting and interpretation of data.

The Project aims to develop a standardised process, including resource material that could effectively illustrate examined data and return it to Aboriginal communities. The key deliverables enable the development of a coherent process illustrating how data and key messages examined should be returned to Aboriginal communities.

NACCHO intends to undertake a pilot test of the developed material, gather outcomes and communicate these with the Aboriginal Community Controlled Health Sector (ACCHS).

NACCHO identified three ACCHSs representing an urban, rural and remote community. These ACCHSs based in the varying settings illustrate the different experiences relating to data collection, ownership, storage, security, access, release, usage, reporting and interpretation.

Medicare

In November 2009 NACCHO prepared and provided a summary analysis of the government's legislative responsibilities regarding Medicare Bulk Billing and Section 19(2). Exemptions under Section 19 (2) of the *Health Insurance Act 1973* permit services to claim Medicare rebates whilst also receiving State or Commonwealth funding (such as for salaries).

NACCHO alerted Affiliates in January 2010 of changes to MBS items designed to streamline and reduce red tape.

NACCHO subsequently submitted a response to the DOHA *Discussion Paper: Development of a Quality Framework for the Medicare Benefit Schedule* (April 2010). This is an Australian Government initiative from the 2009-10 Federal Budget to implement an evidence-based framework for the MBS and is aligned with other federal health reforms such as the National Health and Hospitals Reform.

NACCHO wrote to support the proposed Quality Framework for the Medicare Benefits Schedule (MBS). It is clear that the reforms will improve the transparency of processes

through which MBS items are listed and revised, as well as their appropriateness, safety and effectiveness. It was advised that where an application for a new MBS item or revision of an existing item pertains to the health of Aboriginal peoples that the assessment of the application include technical and community advice provided through NACCHO.

In May 2010, NACCHO appraised the final draft report: *Medicare Modelling Study in Indigenous Specific Primary Health Care Services* commissioned by OATSIH who found the appraisal "added a huge amount of value to the final report".

In June 2010, NACCHO submitted an application form to DOHA to enable Aboriginal Health Workers (AHW) outside the NT to claim the same rebates. This promotes equity, and encourages the employment of AHW across Australia. It also eliminates the disadvantage faced by ACCHSs in reaching the Tier 2 threshold for the Indigenous PIP.

Medicare Locals

In May, the Government announced 'Medicare Locals' would be its preferred local primary health care organisations without defining their relationship to our Sector. At the same time, the Government had rejected the Aboriginal Health Authority recommended by its National Health and Hospital Reform Commission (NHHR). NACCHO held a meeting (June 2010) to discuss our Sector's position on the Federal Government's primary health care reforms, in particular Medicare Locals.

The main points of NACCHO's position developed at the workshop are below:

1. NACCHO is represented on the Transition Committee, as it requires NACCHO's skills and expertise to address Aboriginal health effectively with the implementation of the reforms.
2. There be established, specific Primary Health Care Organisations in urban, regional and remote regions throughout Australia to provide dedicated Aboriginal and Torres Strait Islander health functions pertaining to the integration and coordination of primary health care services for the Aboriginal and Torres Strait Islander population. These 'Aboriginal and Torres Strait Islander PHCO's' would function for all Aboriginal and Torres Strait Islander stakeholders in regional planning/development, coordination and consistent and standardised approaches to: quality improvement/safety; primary health care integration; regulation compliance; performance management and identification of areas of "market failure" and action to address service access gaps.
3. NACCHO should be afforded resources for the detailed articulation of this proposal. Specifically, NACCHO seeks funding to develop and implement a transition strategy to enable/ provide:
    a. A sufficient timeframe to consult with our Sector regarding the reforms and to synthesize this information into a report. NACCHO will then provide Government decision makers with an analysis of the key issues involved for the ACCHS sector in establishing Medicare Locals and a practical plan for involvement, development and implementation of Aboriginal and Torres Strait Islander Australian PHCOs- that support comprehensive Primary health Care to the Aboriginal and Torres Strait Islander population.

   b. A discussion of the key strategic and organisational issues required to transition existing ACCHS network infrastructure into a new level of operation required from MLs and for Aboriginal and Torres Strait Islander Australian PHCOs.
   c. A guide to the practical steps involved for all levels of the ACCH sector in the establishment of Aboriginal and Torres Strait Islander Australian PHCOs and their intersection with ML's – e.g. Boundaries, Partnerships, Governance, Membership etc.
4. The ACCH Sector will identify how we will strengthen our networks and relationships, and review our operations so we are actively engaged in the new health environment created through the reform process.
5. The ACCHS sector be given the opportunity to submit expressions of interest to develop specific Aboriginal and Torres Strait Islander Primary Health Organisations in addition to the 15 Medicare Locals by July 2011.
6. In addition to the establishment of APHCOs NACCHO continues to support the need for a National Aboriginal Health Authority which would be the principal funder of the APHCOs and oversee the development of Aboriginal community controlled health services and a more responsive health system through the nation. NACCHO will need to be involved in further negotiation with the government in order to establish the NAHA.

Research

NACCHO frequently receives requests to appraise research proposals, findings and reports. Below is a sample of the work undertaken in this area during the period:

- NACCHO appraised two draft reports regarding the development of Service Activity Reporting from ACCHSs providing feedback to OATSIH;
- NACCHO appraised the NHMRC HOMER[12] project (Aboriginal subgroup) which aims to harmonise ethical review of multi-centre research applications into a simplified single ethics application;
- Survey questions for the QUMAX Program were reviewed by NACCHO prior to their finalisation;
- NACCHO is working with the Burnet Institute and National Centre for HIV Epidemiology and Clinical Research (NCHECR) to support ACCHSs in the Chlamydia surveillance program;
- NACCHO wrote to the Menzies School of Health Research in April 2010 inviting them to partner with NACCHO in the development and implementation of the proposed research project: *'An Australian Indigenous cohort of the International Tobacco Control Policy Evaluation Project';*
- NACCHO continues its watching brief over the reports produced by the Trachoma Surveillance and Reporting Unit managed by the University of Melbourne and funded by OATSIH; and
- Staff within NACCHO also appraised a number of reports such as the AIHW report on *'Expenditures on Health Services for Aboriginal and Torres Strait Islander People'.*

[12] Harmonisation of Multi Centre Ethical Review (Homer) Project.

Research Policy Portfolio

The Research Policy portfolio is new to the National Secretariat and a Research Coordinator commenced at NACCHO in November 2009. The key role is to provide Coordination for the Clinical Centre of Research Excellence (CCRE), which is a collaborative project between NACCHO and the National Centre in HIV Epidemiology and Clinical Research (NCHECR). The work is supported by a Memorandum of Understanding (MOU) between NACCHO and NCHECR.

The CCRE will receive funding of $2.5 million over five years from the National Health and Medical Research Centre (NH&MRC) and will focus on researching sexually transmitted and blood borne viral infections in urban and rural communities. Five member services have agreed to act as clinical sites for the CCRE. Our goal is to create a community-controlled research centre where each community decides research priorities, how to undertake the research, and manage and disseminate any research results. The Research Policy Officer has a key role in developing capacity amongst the CCRE participants.

The CCRE provides funding for two research coordinator positions located at NACCHO and NCHECR. The first activity of the Coordinators was to visit each of the ACCHS sites to build relationships and to start conversations around research interests and capacity development requirements.

The annual face-to-face meeting of the CCRE occurred in June 2010 in Melbourne. Representatives from each ACCHS, NACCHO and NCHECR met to review the progress already made in the CCRE and to plan for the research to be undertaken during the coming year. The meeting agreed to pursue four areas of research:

- Antenatal testing for Sexually Transmitted Infections (STIs);
- Hepatitis C management;
- STIs and young people; and
- Prisoners' health.

These broad areas of interest have the potential to lead to many different research projects which will assist to inform and strengthen the management of sexually transmitted and blood borne viral infections in the community controlled sector.

The research policy officer is the key NACCHO liaison on an ARC Linkage Grant, a large collaborative project involving NCHECR, NACCHO, all state and territory Affiliates and Departments of Health. The project is entitled: *Sexual health and relationships in young Aboriginal and Torres Strait Islander people: The first Australian national study of knowledge, risk practice and health service access*, and will use PDA technology to survey young people at cultural and sporting events in each jurisdiction.

Recognising the importance of the NACCHO Data Protocols (1997) to the ongoing work of the CCRE, NACCHO assisted revise the Protocols, with the research policy portfolio aiming to support the Protocols by producing resources that will support their use, including a shorter, health worker friendly version for use at our Clinical Sites.

Alcohol and other Drugs

During the past twelve months, NACCHO continued to actively participate as a member of the National Indigenous Drug and Alcohol Committee (NIDAC) by attending all meetings and assisting set the agenda for its program of activities. NACCHO's membership of NIDAC is proactive and we were involved in a range of activities including co- presenting and launching at Conferences and Seminars related to drug and alcohol.

In April 2010 NACCHO was invited to participate in the launch of the NIDAC commissioned report entitled: *"Indigenous Specific Alcohol and Other Drug Interventions: Continuities, Changes and Areas of Greatest Need." NACCHO provided technical advice to the report through its membership of NIDAC*. One of the key messages promoted by NACCHO and contained in the final report relates to the need for greater funding for culturally appropriate Alcohol and Other Drug (AOD) services for Aboriginal Australians and the lack of dedicated funding for existing services. The Report is significant as it is the only study to provide detailed longitudinal data on the range and provision of AOD services / treatment for Aboriginal Australians.

NACCHO partnered with ANEX through membership of the Reference Group to provide expertise, technical advice and review, shape the research and its protocols and assist the researchers with access to 'key informants' on a Report commissioned by the Australian National Council on Drugs (ANCD). The report was entitled *Injecting drug use and associated harms amongst Aboriginal Australians"* and explored the barriers and enablers to services, treatment modalities, the lack of culturally appropriate services for Aboriginal drug users and that current service delivery (with some notable exception) was often met by the Sector through general funds rather than dedicated funding streams and established programs. It highlighted the disproportionate allocation of funds directly the Sector as opposed to mainstream services.

One of the highlights during this period was the inaugural National Indigenous Drug and Alcohol Conference in Adelaide which attracted more than 550 delegates. NACCHO, as a member of the conference organising committee actively promoted the conference to the Aboriginal Community Controlled Health Services sector. The conference provided the opportunity for the Sector and other Aboriginal organisations to showcase the range of innovative programs, their commitment, linkages and networking with other agencies and the solutions adopted in the Sector. Further, it provided the opportunity to exchange information and highlight the importance of addressing drug and alcohol use in the Aboriginal community. A significant outcome from the Conference themed *Listening, Learning and Leading*, was that the delegates and the ANCD agreed that the future health and well-being of Aboriginal and Torres Strait Islander people must be led by Aboriginal and Torres Strait Islander peoples in co-operation with the wider community and governments.

Sexual and Reproductive Health and Blood Borne Viruses

In August 2009, NACCHO was invited to join the Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Expert Writing Reference Group with the aim of

assisting in the development of the *Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010–2013*.

NACCHO's contribution to the Reference Group included the following:

- That Aboriginal Community Controlled Health Service's are adequately resourced to address the burden of disease related to Sexually Transmitted Infection's and Blood Borne Viruses;
- Equity in workforce allocation and payment across jurisdictions based on identified need; and
- Ensure that any future national strategy has achievable and real indicators that can be measured over the term of the strategy.

The Strategy was formally accepted and endorsed at an Australian Health Ministers Conference in April 2010 and launched by Minister Warren Snowdon in June 2010.

NACCHO continues to maintain a Sexual and Reproductive Health and Blood Borne Virus Advisory Committee. This committee meets quarterly and remains the only Aboriginal Community Controlled committee to meet and discuss these issues at a National level. Whilst this Committee's main function is to provide key advice to the NACCHO Board of Directors it is increasingly being utilised as a source of advice for our key partners in the sexual and reproductive health and blood borne virus sector. It continues to provide an avenue to support the ongoing development of STI, HIV/AIDS and BBV and Reproductive Health programs within Aboriginal Community Controlled Health Organisations (ACCHO).

The Memorandum of Understanding (MoU) between NACCHO and the National Centre in HIV Epidemiology and Clinical Research (NCHECR, UNSW) continues to prove beneficial to NACCHO our State and Territory Affiliates and Member services. Earlier this year, NCHECR released their 2009 *Blood Borne Viral and Sexually Transmitted Infections in Aboriginal and Torres Strait Islander People: Surveillance Report*. This report is used to inform the Aboriginal Community Controlled Service sector regarding our research efforts in this area.

Australian Collaboration for Chlamydia Enhanced Sentinel Surveillance (ACCESS)

A formal Memorandum of Understanding (MOU) between the Burnet Institute (BI), National Centre in HIV Epidemiology and Clinical Research (NCHECR) and NACCHO was developed to guide the establishment and implementation of the Australian Collaboration for Chlamydia Enhanced Sentinel Surveillance (ACCESS) Aboriginal Community Controlled Health Organisation Network (ACCHON).

The ACCESS project aims to support better understanding of Chlamydia epidemiology in Australia. ACCESS comprises five additional national surveillance networks established in Sexual Health Clinics, Family Planning Clinics, Antenatal Clinics, General Practices and Laboratories. Each network collects demographic and Chlamydia testing data arising from routine clinical practice that is used to measure Chlamydia testing and infection rates.

The ACCESS Aboriginal Community Controlled Health Services Network has demonstrated the feasibility of establishing a sentinel surveillance system to determine the extent of chlamydia testing and infection from routinely collected data. Essential to establishing the ACCHS network has been ensuring the system meets the needs and respects the values of Aboriginal and/or Torres Strait Islander peoples, communities and health services whilst incorporating the overall design of the ACCESS system.

Aboriginal Women's Health

The Australian Women's Health Network (AWHN) is the peak women's health body in Australia. AWHN is run by volunteers and provides a national voice on women's health through advocacy and information sharing. AWHN hosts a National women's Health Conference every five years. This year the conference was held in Hobart from 18-21 May 2010 and provided a perfect platform to launch the National Women's Health Policy, which NACCHO was consulted on and provided input to its development during 2009.

The Talking Circle within AHWN represents Aboriginal and Torres Strait Islander women's health issues. AWHN and the Talking Circle successfully lobbied the Australian Government for the re-formulation of new *National Women's Health Policy,* and a subsequent *National Aboriginal and Torres Strait Islander Women's Health Strategy*. NACCHO members also contributed to the Strategy through Workshops held at our Darwin 2009 members meeting and further NACCHO secretariat involvement.

Extensive consultation occurred with over 400 Aboriginal and Torres Strait Islander women across Australia. The completed strategy was also launched at the National Conference in Hobart. NACCHO formally presented to the conference.

NACCHO has also cemented its membership on the AHWN Committee and will be heavily involved in the implementation of the strategy.

Aboriginal Men's Health

Following an extensive consultation process, the NACCHO Board of Directors endorsed the NACCHO Policy and Position Statements on Aboriginal Male Health in May 2010.

NACCHO also participated in the Australia wide consultations for the development of the *Australian Governments National Men's Health Strategy.* The strategy was jointly launched in May 2010 by the then Prime Minister Kevin Rudd and the Minister for Indigenous Health, Warren Snowdon. It included $6 million in funding commitments to improve Aboriginal and Torres Strait Islander men's Health and reflects many of the recommendations made in NACCHOs position statements

Communications

The NACCHO Chair and other designated spokespeople gave media interviews throughout the year. In addition, NACCHO provided written media commentaries produced *Take Note* newsletters and issued 16 media releases.

NACCHO also worked closely with the Close the Gap Steering Committee members regarding communication strategy and joint media statements, which included quotes from the NACCHO Chair.

NACCHO Press Releases during the year covered a range of issues. Below are key releases which generated media interest:

- 10 June 2010: Vigilance and workers key to new Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy;
- 12 May 2010: No Frills, No Strategy in Aboriginal Health Budget: NACCHO;
- 7 May 2010: First National Male Health Policy welcomed by Aboriginal men;
- 16 March 2010:Health workforce boost vital to Close the Gap Re the $632m package for training doctors;
- 29 January 2010: Aboriginal Health Workers formally acknowledged;
- 11 December 2009: Letter to the editor of The Australian re Centre for Independent Studies report;
- 11 November 2009: New Chair Elected to Peak Aboriginal Health Body;
- 30 October 2009: Federal government losing the way on closing the gap; and
- 29 July 2009: Aboriginal Health Authority needs developing.

Close The Gap Coalition Campaign

As a founding member NACCHO continues to play an active role in the Close The Gap Coalition and the campaign's Steering Committee established to address health inequality between Aboriginal and non Aboriginal Australians.

Members of the NACCHO Board and other ACCHS delegates attended the 'Close the Gap – Making it Happen' workshop (June: Old Parliament House) together with members of the Close the Gap Coalition and health experts from across Australia's non-government and government sectors.

Delegates endorsed the *Statement of Intent*. In particular, support for 'Indigenous' Community Controlled Health Services and their peak bodies as central to the design and delivery of services for our people.

The workshop coincided with the appointment of The Hon. Julia Gillard as Prime Minister. She was encouraged to recommit to the *Indigenous Health Equality Statement of Intent* signed by the Government and Opposition in 2008.

REPORTING ON STRATEGIC PRIORITIES: BUILD AND ENHANCE ACCHSS CAPACITY TO PROVIDE MORE EFFECTIVE/EFFICIENT PRIMARY HEALTH CARE SERVICES

Medicines Access

NACCHO remains active in shaping and formulating health policy that promotes and enables equitable medicines access for the Aboriginal and Torres Strait Islander population. It does this through QUMAX, the PBS Co-Pay Relief Program and the ICDP measure. The following describes other measures for accessing medicine:

Quality Use of Medicines Maximised for the Aboriginal population (QUMAX)

The QUMAX Program provides funding for better access to medicines and pharmacist support to registered ACCHSs in non-remote areas. This has been managed through a partnership between NACCHO, the Pharmacy Guild of Australia (Guild) and the Australian Government Department of Health and Ageing (DOHA).

From June 2009 to June 2010, the program provided funding and support to ACCHS via NACCHO/ Guild management arrangements, State Affiliates support and by the appointment of QUM Pharmacists. The program also provided structured support for improving Quality Use of Medicines (QUM) in ACCHSs, by providing capped funds to ACCHSs to allocate funds for: medicines (PBS co payment relief); provision of DAAs (Webster packs etc); Facilitation of Safety Net calculations; Transport support for the delivery of prescriptions or medicines; and Medication devices (Nebulizers, Asthma Spacers etc).

Early indicators point to the Program achieving its objectives of improving quality use of, and access to, PBS medicines in participating ACCHS.

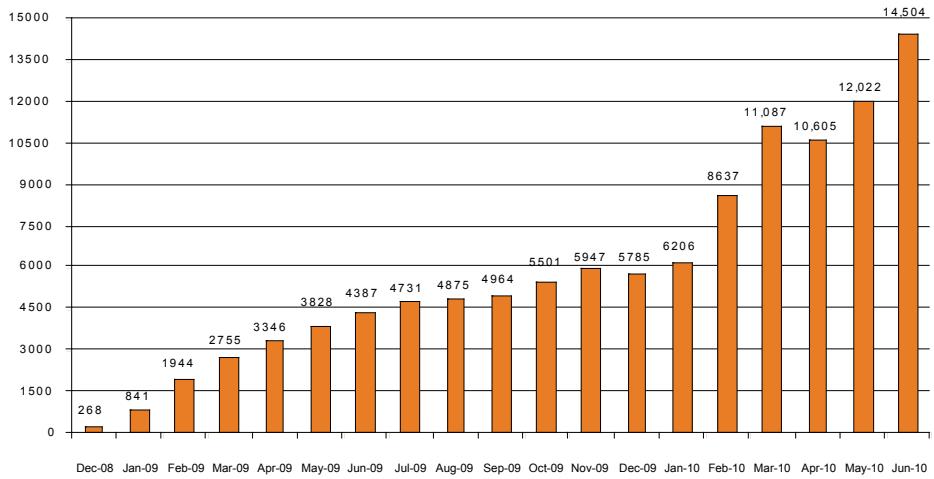
QUMAX Usage (PBS co – pay relief and DAAs) to June 2010[13]

By the end of June there were 69 ACCHSs actively prescribing under QUMAX and issuing DAAs along with 541 pharmacies actively dispensing QUMAX prescriptions.

The total number of clients receiving QUMAX prescriptions was 33,924, with 578,692 prescriptions written by ACCHS doctors. Services ordered a total of 152,257 DAAs for patients on multiple medications. $1,033, 672 was allocated to PBS and DAAs by services for use during the 2009–2010 period.

[13] Source: Urbis QUMAX Data Update June 2010

Figure 1 – Monthly Number of MAAPs allocated[14]



Urbis data analysis for the QUMAX program made the following observations regarding the graph above:

- The number of MAAP allocations, as expected, rose steadily in the first six months of the project as services came on board and became more familiar with QUMAX processes;
- Allocations reached a plateau in August and September 2009 as services settled with their budget allocations; and
- Allocations rose sharply in February, March and June 2010 as services became more certain of the extension of QUMAX to 30 June 2010, and the commencement of the COAG Closing the Gap PBS Co-payment Measure from 1 July 2010.

Outcomes 2010

During the past year, ACCHS have streamlined their QUMAX procedures and reported to NACCHO that early positive health outcomes were becoming evident. These improved outcomes are directly related to the removal of the cost barrier and its flow on effects for both services and patients.

Other outcomes, beyond improved access to medicines, are starting to emerge. In many instances QUM Pharmacists have established strong relationships with the ACCHSs and assisted in QUM improvements other areas. These include: improving recording and monitoring of safety net status of clients; educating health service staff and clients on QUM; liaising with pharmacies and ACCHSs to improve management of dose

[14] Urbis QUMAX Data Update June 2010

administration aids; providing advice to ACCHS on medicine stock control and brokering better access to QUM services such as Home Medication Reviews (HMRs),

The QUMAX program has been very well received by our Members with many reporting to NACCHO their satisfaction. Below is one example of the letters of satisfaction / support NACCHO has received. The clinic manager at Bendigo and District Aboriginal Co-op Victoria wrote:

> *"At the Bendigo and District Aboriginal Co-operative the QUMAX Program has been a blessing as it has enabled our community financial assistance to fill their prescriptions, supported the high expense of medications for chronically ill patients and supported the better utilisation of home medication reviews. We have built a great relationship with the participating chemist and this has initiated the start of talks for other support program such access to an optometrist for our patients with discounted glasses and lenses.*

In the evaluators' May 2010 progress report to the Department they stated that QUMAX was regarded by ACCHS as having:

> *"Increased patient access to medicines; increased patient compliance; increased patient access to QUM; improved relationships with community pharmacies; increased staff access to QUM material and training resources; and development of new protocols, policies or procedures leading to improved quality of care. "*[15]

The pilot program was scheduled to conclude in March 2010. However NACCHO, with strong support from ACCHS, secured an extension of the Program management arrangements and funding elements until June 2011.

We are pleased to report that in 2010, funding was approved for the extension of the non co-payment elements of QUMAX to June 2011. The new arrangements for PBS Co-payments are reported below.

Most importantly, a new QUMAX model was funded under the 5th Community Pharmacy Agreement to 2015. NACCHO is in discussions with the Department and the Pharmacy Guild of Australia regarding the features of the new QUMAX

QUMAX – New Arrangements in place

The *Indigenous Chronic Disease Package PBS Co-payment Measure* (ICDP) provides for assistance from 1 July 2010 in the form of lower or nil patient co-payments for PBS medicines. This measure replaces the QUMAX arrangements for Co-payment of medicines for ACCHS clients in services participating in QUMAX. However the other elements of the QUMAX program have been extended and enhanced.

[15] Evaluation of the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples (QUMAX) Program Progress Report May 12 2010

NACCHO developed an evidence-based proposal for extension and enhancements to the Program. They key elements of the proposal included:

- The continued provision of funds to ACCHS for PBS medicines until the new scheme is available on the 1st July 2010;
- The continued provision of funds to ACCHS for DAAs, Transport and Education, QUM Education and Cultural Training from June 2010 to June 30 2011;
- The continuation of NACCHO/ Guild management arrangements to June 30th 2011;
- The funding for State Affiliate involvement and QUM Pharmacist support to ACCHS to June 2011; and
- The expansion of the NACCHO communication system and the development of an Online Cultural Training Inventory.

This proposal was accepted by the Department and endorsed by the Pharmacy Guild of Australia as an extension of the QUMAX 4th Community Pharmacy Program. ACCHSs currently participating in QUMAX were eligible to participate in the extension of the program.

QUMAX Extension Program

NACCHO developed the new QUMAX online data and work plan management system to collect and collate the new information required for funding services in the extension year. This work was completed in May 2010 and by 30 June 2010, services had reregistered for QUMAX and over 90% of QUM work-plans were submitted.

The QUM work plans document ACCHS strategies and policies to:

- Integrate with the Indigenous Chronic Disease Package PBS Co-payment Measure (ICDP);
- Improve quality prescribing and dispensing including Cultural Training for pharmacy staff;
- Improve ACCHS clients compliance with prescribed medicines through improved transport, subsidized DAA and medication devices, and education for AHWand clients to manage medications.

The QUMAX program extension funding and work plans have improved a range of functions as it allows Services to allocate funds according to service and client requirements across the following categories:

- Policy and Protocol Development
  - Planning linked to ensuring effective QUM outcomes and 'Close the Gap (CTG) PBS Co-payment measure' implementation within the QUMAX program arrangements.
- QUM Devices
  - Enhanced purchasing or leasing of required devices, which improve medication delivery. E.g. Nebulizers, Spacers, etc.

- Dose Administration Aids (DAAs)
  - Applying a criteria to determine patient eligibility for DAAs.
- QUM Education
  - The educational initiatives required to support QUMAX such as resources, client education/ health promotion sessions related to management of chronic diseases and medication management or safety net participation, QUM education for staff, and support for the Good Health Better medicines implementation.
- Cultural Awareness Training
  - NACCHO will be developing a National Cultural Training Inventory to showcase ACCHS and Sector involvement in the provision of cultural training and advice. This work will occur from July 2010.
- Transport support
  - QUMAX has successfully provided support and facilitated the transition to the Closing the Gap (CTG) PBS Co-payment measure and the new Practice Incentive Program Indigenous Health Incentive.

Expert Advisory Panel on Aboriginal and Torres Strait Islander Medicines

NACCHO is a member of the Expert Advisory Panel on Aboriginal and Torres Strait Islander Medicines. This forum provides advice to DOHA and to the Pharmaceutical Benefits Advisory Committee and facilitates listing of medicines on the PBS to meet Aboriginal peoples pharmacy health needs.

This year's outcomes include the new listing of medicines including antifungals, thiamine, ototopical ciprofloxacin, nicotine replacement therapy, calcium and other medicines for the Aboriginal population.

NACCHO has placed on the agenda for ongoing discussion the following:

nicotine replacement therapy (in gum form), albendazole in higher dosage form for strongyloidiasis (listing extended in March 2010), calcium (calci-tabs was PBS listed as from Dec 2009), ivermectin for encrusted scabies, mycophenolate sodium (to extend to nephritis eg in systemic lupus erythematosis), magnesium/bicarbonate (for kidney failure (bicarbonate was listed Sept 2009), lactulose (now on the PBS for hepatic failure), aluminium hydroxide (for kidney failure), zinc and vitamin D supplements.

NACCHO continues to appraise these medicines and monitor PBS uptake through this forum.

Medicines supply to remote areas under Section 100

In September 2009, a discussion paper *'Review of the existing supply and remuneration arrangements for drugs listed under Section 100 of the National Health Act 1953'* was

released. This Review examined the existing supply and remuneration systems for community pharmacists providing medicines under S100 to Aboriginal health services. NACCHO prepared a response to the Review highlighting:

- The degree of PBS expenditure is still below that needed;
- The S100 Support Allowance can supplement funds for ACCHSs to employ pharmacists;
- Financing Dose Administration Aids (DAA) to Aboriginal clients of ACCHSs;
- The need for a coordinated national approach to quality use of medicines (QUM) support; and
- Improving the medications knowledge of AHWs.

Fifth Community Pharmacy Agreement

NACCHO continued its membership of the Professional Programs and Services Advisory Committee (PPSAC) Rural and Indigenous Steering Committee. NACCHO assisted to monitor the 4th Community Pharmacy Agreement (CPA) programs including the QUMAX and S100 Support Allowance to pharmacists. The 4th Agreement programs expired in 2010 and a new Agreement was signed between the Australian Government and the Guild in May 2010.

NACCHO undertook a great deal of work to promote the continued funding of QUMAX in partnership with the Guild and with the support of the PPSAC. The 5th Agreement provided additional funding for the continuation of the QUMAX program for the next five years. The 5th CPA also continues to fund the S100 Support Allowance, and Home Medicines Review. NACCHO was appointed as membership to the newly developed Program Reference Group to oversee the above programs.

Good Medicines Better Health Project (GMBH)

NACCHO, the Aboriginal Health Council of South Australia (AHCSA) and the National Prescribing Service (NPS) rolled out a "Good Medicines Better Health" (GMBH) pilot project. The project was designed to assist Aboriginal Health Workers improve their knowledge and skills about medicines based on the principals of Quality Use of Medicines

In 2010 NACCHO met with the NPS to determine the National Roll Out. The two Affiliates commencing the National Roll Out of the GMBH Program are AHCSA and VACCHO.

A suite of complimentary GMBH resources were developed during this period along with a Community Information Resources Register. The register tracks the distribution of the materials to Services together with a survey to capture information regarding use of resources and their cultural appropriateness.

Eye And Ear Programs

$58.3m was secured for the Programs *"Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcomes"*. NACCHO contributed to several programs managed by OATSIH under this investment.

OATSIH Planning and needs analysis of hearing equipment' for the purchase and maintenance of hearing equipment for hearing screening.

ACCHSs, Healthy for Life sites, and services in the COAG priority remote areas are eligible for free equipment and its maintenance and calibration. NACCHO provided advice (12th January 2010) to the consultant, Access Economics on: defining core equipment needs (regardless of epidemiology), service capacity including workforce knowledge of otitis media and its treatment, optimally effective referral systems, provision of school screening, and health promotion activity for the community.

An internet survey was appraised by NACCHO with significant edits, in order to assess the status and distribution of equipment for screening otitis media and related hearing problems (the stock-take will include soundproof rooms) and workforce capacity to undertake such screening. The survey aims to guide the distribution of equipment to services that need it.

NACCHO undertook a detailed technical appraisal of the revised draft of the Guidelines on Otitis Media and provided it to the consultants and OATSIH.

A NACCHO appointed a representative to the National Aboriginal Hearing Campaign Reference Group in February 2010.

Senate Inquiry

In October 2009 NACCHO submitted to the *Senate Inquiry into Hearing Health in Australia regarding* the burden of disease affecting the Aboriginal population and the need to audit the Australian Government's spending on the Commonwealth Hearing Services Program and Australian Hearing, so that the frequency of service provision to this population is equitable and commensurate with need.

The Senate Inquiry report recommended "urgent priority be given to hearing screenings and follow up for all Indigenous children from remote communities on commencement of school".

Training in Hearing

The Australian Government launched the 'Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcomes Measure' in 2009. This investment of over $58 million over four years will work toward expanding ear and eye health services in Aboriginal communities. During this period NACCHO was successful in securing funding to develop and implement Professional development training to AHWs regarding the use and care of ear and hearing equipment along with developing an accredited course and holding an Aboriginal and Torres Strait Islander ear and hearing care symposium.

NATIONAL GUIDE

The revision of the *National Guide to a Preventive Health Assessment for Aboriginal and Torres Strait Islander People* was agreed between NACCHO and the RACGP. NACCHO originally conceived of the National Guide in 2000 and in 2005 it was first published jointly with the RACGP. NACCHO owns the intellectual property for this guideline. This revision project was funded by the DOHA as part of the C5 measure of the ICDP. The Guide is used throughout Australia and forms a vital tool assisting with adult and child health checks. A revised Guide should be completed by March 2012.

Cultural Safety Training

Creating an environment of cultural safety in health services to ensure responsive and culturally appropriate care continues to remain core business of NACCHO, State Affiliates and its Members. NACCHO's approach to Cultural Safety Training (CST) was articulated in our submission to the development of the National Primary Health Care Strategy and guides our response to any program or component of CST. Briefly, this guiding philosophy remains:

> *Services that are not Aboriginal community-controlled, by definition, cannot deliver culturally appropriate primary health care. However, services that are not Aboriginal community-controlled can be encouraged to deliver healthcare that is culturally secure. A definition and program prepared by the ACCHS sector for the delivery of Aboriginal cultural safety training for mainstream health services should be supported.*

Work to establish a set of Aboriginal Community Controlled Health (ACCH) Sector endorsed Cultural Safety Training Standards that align with sector is now in progress. Endorsed Sector standards are required for the mainstream health sector, particularly given the expansion of programs and servicing into a mainstream setting due to the COAG measures, partnerships and significant financial investment in Aboriginal health.

The Office for Aboriginal and Torres Strait Islander Health (OATSIH), has agreed to a proposal to establish Stage One of a Cultural Safety Training (CST) Standards Project. The full elements of the Project are currently under negotiation. However, agreement to allocate existing funds in the interim progressed the development of the two main components. This involves:

- Creating NACCHO National Standards for Cultural Safety Training; and
- Creating a searchable inventory and database on Cultural Safety Training and associated resources.

Since establishment of the PIP Indigenous Health Incentive NACCHO and its State and Territory Affiliates have experienced a marked increase in requests from Medical professionals regarding CST. The CST Project aims to position the Community Controlled Health Sector to respond to these requests for CST by providing Sector developed

and endorsed standards that define the minimum requirements and conditions of cultural safety training. Further, Sector driven CST can form the basis for negotiating or recommending training options with GPs and other health professionals.

NACCHO will be developing a National Cultural Training Inventory to showcase ACCHS and Sector involvement in the provision of cultural training and advice. This work will occur from July 2010.

The project will be guided by a Cultural Safety Training Standards Reference Group and the NACCHO Standards will be developed and endorsed through a Cultural Safety Training Standards Committee with sector-only membership

Accreditation of Services Program

Establishing Quality Health Standards (EQHS)

The Budget measure – *A Better Future for Indigenous Australians – Establishing Quality Health Standards* (EQHS) provides funding until 30 June 2011 to assist eligible Aboriginal Health Organisations funded by the Department of Health and Ageing through the Office for Aboriginal and Torres Strait Islander Health (OATSIH) to become accredited against Australian health care standards.

Local support funding was secured by NACCHO and Affiliates to provide information and education, promotion and support, learning and development for member services undertaking accreditation.

Accreditation Toolkit Suite – EQHS

The ACCH Sector identified the importance of developing an "Accreditation Toolkit Suite" related to our sector and our service requirements. The following Manuals and Guides were developed and jurisdictional training sessions were held in partnership between NACCHO, Affiliates, OATSIH and Accreditation Agencies.

OATSIH Accreditation Manual: This Manual is intended to demystify accreditation processes for organisations pursuing accreditation under the EQHS Budget measure. The Manual has drawn on contributions from Aboriginal Community Controlled Health Organisations that have already achieved accreditation to enable unaccredited ACCHS's gain a greater understanding of the process and benefits of accreditation and drawn from their experiences.

Interpretive Guides: These Guides are intended to interpret RACGP and QIC Standards as they pertain to an Aboriginal Community Controlled Health Service, and to assist organisations prepare for accreditation under these standards.

Accreditation Outcomes – EQHS

The following figures were provided to the Sector by OATSIH regarding the percentage of eligible services that have engaged in EQHS:

- Prior to implementation of EQHS approximately 35% of eligible organisations were accredited – almost all of these under RACGP Standards;
- Following the introduction of EQHS support measures, 67% (141) of the 210 eligible OATSIH-funded organisations accessed one or more forms of accreditation support under EQHS;
- Around 90% of these 210 organisations are currently working with their funded peak body organisations in pre-accreditation or accreditation related activities;
- 23 organisations have achieved first time or re-accreditation with the help of EQHS; and
- 92% of organisations intend to become accredited in the future.

Aboriginal Health Workforce

Award Modernisation

The Australian Industrial Relations Commission conducted the award modernisation process throughout 2009. Solicitors Blake and Dawson acted pro bono for NACCHO and tendered a number of submissions on our behalf to ensure the award encapsulated the uniqueness of our sector and workforce.

The foundation of the government's "Forward with Fairness" reforms was the creation of National Employment Standards (NES) or minimum entitlements for all workers. The aim was for "modern" awards to complement the new National Employment Standards and contain provisions tailored to the requirements of particular industries and occupations.

The process for Award Modernisation is a highly specialised and complex area and the challenge for NACCHO was to ensure that the Sector was not 'forgotten' and assumed into other Awards. It was essential that NACCHO engage in the Award Modernisation process and secure a Sector Award as the myriad of existing Awards were to be dissolved. Securing an Award was a significant outcome for the Sector as it acknowledged the unique nature of the Sector and provided a base line for renumerating AHW, which allows the Sector to advocate for greater government funding to meet the new Award minimum standards.

To achieve this outcome NACCHO accompanied the Industrial Relations Commissioner to a variety of Services so he could personally witness and understand the variety and depth of work undertaken, the conditions under which Services operated and the diversity of the Sector to highlight the unique nature of the Sector.

The National Employment Standards and Modern Awards came into effect on 1 January 2010. The National Employment Standards cover matters such as maximum weekly hours of work, types of leave, termination notices and redundancy pay, and requests for flexible working arrangements. Complementary Modern Awards contain provisions regarding: minimum wages, types of employment, arrangements for when work is performed, overtime and penalty rates, allowances, leave related matters, superannuation and procedures for dispute settlement. They also contain a mechanism for employers and employees to negotiate variations in conditions. These variations cannot set lower conditions or standards, as the purpose of the Award is to set minimum standards for compliance.

The modern awards are applied primarily to an industry but there are also awards which are occupationally based and not captured under a specific award. An organisation is likely to be covered by a modern award, whether or not it is currently covered by a transitional state award, or is a specific respondent to a federal award.

NACCHO continues to be mindful of the impact that the award may have on services' ability to meet minimum conditions and remuneration under the new rates due to funding shortfalls. Further, it is acknowledge that currently many services pay above the award rates and that in transition to the new system no workers are worse off due to changes in the whole industrial relations reform process and introduction of Sector Award.

All information regarding the consultation process, submissions provided to the Commission, and copies of the new Awards have been circulated have been circulated widely and have also been made available to the Affiliates Workforce Issues Policy Officers (WIPO) for distribution and to assist enquiries.

Under NACCHO guidance and leadership, the WIPOs will continue to support NACCHO's members by working to address issues that arise in the implementation of the new Award.

The National Accreditation and Registration of Aboriginal Health Workers (AHW)

In response to submissions, including NACCHO's, the Australian Health Ministers' Advisory Council (AHWMC) announced that from the 1st July 2012 AHW would be included under the New National Registration and Accreditation Scheme. The registered title will be 'Aboriginal Torres Strait Islander Health Practitioner.' This announcement has also trigged the funding of a large-scale project to be conducted by the newly formed Health Workforce Australia. NACCHO has been instrumental in designing the parameters of this project and will continue to advocate for its relevance to our Sector.

National Aboriginal Torres Strait Islander Health Worker Association (NATSIHWA)

NACCHO supported the formation of the National Aboriginal Torres Strait Islander Health Worker Association (NATSIHWA) and recruitment of members as part of the process leading to National Registration and Accreditation by holding consultation workshops for AHWs and auspicing the NATSIHWA for a short time.

NACCHO supported the WIPO Network to undertake the recruitment drive to foster increases in the NATSIHWA membership.

Liaison between NACCHO and NATSIHWA and NACCHO and the WIPOs ensured the planning and strategies undertaken will deliver a positive result with respect to uptake of memberships. These discussions resulted in the updating of the application form, power point presentations, and information regarding the nomination and voting processes.

In March NATSIHWA appointed Alan Brown as CEO. NACCHO met with Mr. Brown and continues to support the association through its establishment phase. Mr. Brown has liaised with the WIPO Network meeting to discuss the progress of the association and outcomes of the recruitment drive.

NATSIHWA has established and staffed an office in Melbourne. NACCHO welcome the new logo and promotional marketing material and look forward to an ongoing and productive working relationship with NATSIHWA.

Aboriginal Torres Strait Islander Health Registered Training Organisation Network (ATSIHRTONN)

NACCHO continues to support the Aboriginal Torres Strait Islander Health Registered Training Organisation Network (ATSIHRTONN). The NACCHO Workforce Issues Policy Officer (WIPO) holds membership on the ATSIHRTONN Executive Members Committee. All Affiliate WIPO's are members of ATSIHRTONN and continue to work towards ensuring training qualifications encompass a nationally uniform structure in which the Aboriginal Health profession can develop and identify career pathways. This includes the gathering and dissemination of materials and provision of advice regarding training matters related to our health workforce. Training and qualifications are fundamental to obtaining Accreditation and Registration, have implications for the new health workforce such as Aboriginal Torres Strait Islander Outreach Workers, Healthy Lifestyle Worker's and Tobacco Action Workers, and potentially membership of the Association.

ATSIHRTONN held two face-to-face meetings and several teleconferences during the period. Outcomes include conducting two scoping projects:

- The ATSIHRTONN Needs Analysis Document; and
- The Scoping Study of Orientation and Training needs for Ear and Hearing Health Workers.

National Aboriginal Torres Strait Islander Health Workforce Working Group (ATSIHWWG)

A new development for ATSIHWWG has been the Co-chairing of the ATSIHWWG meetings shared by NACCHO Chair, Justin Mohamed and Acting Assistant Secretary Health Workforce Division of DOHA, Mary McLarty. These meetings have provided the opportunity for member updates about National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (WSF). In particular, consideration was given to the resourcing, implementation, reporting requirements and an associated community strategy for the framework

Training Package Advisory Committee (TPAC)

NACCHO was invited to be a member of the Training Package Advisory Committee (TPAC). The first meeting of the Committee aimed to determine the following:

- The role of the Training Package Advisory Committee;
- Introduction of the TPAC to the Continuous Improvement (CI) process and priorities; and
- Sought the Committees agreement to ISC's approach to progressing the 2010 work plan.

The Health Training Package Advisory Committee (TPAC) has been engaged to provide governance and oversee the process of Continuous Improvement of the Health Training Package to ensure it reflects industry derived national competency standards, skill sets, and qualifications.

This continuous improvement model for training packages includes consultation processes, stakeholder input, and explores the various changes and alterations to existing training package changes. This process replaces the previous 3-4 year training package review cycle.

Healthy Life Stories Industry Reference Group (IRG)

The NACCHO is an active member of the Industry Skills Council (ISC) Healthy Life Stories Industry Reference Group (IRG).

The Community Services and Health Industry Skills Council (CSHISC) was funded by the Department of Education, Employment and Workplace Relations (DEEWR) to produce a series of promotional materials entitled 'Healthy Stories'. The role of the Industry Reference Group (IRG) is to assist with identification of stakeholders to be consulted, identify cultural and industry issues which may affect the project strategies and provide input, advice and feedback. The IRG have considered potential stories for the pilot and potential champions. NACCHO has advocated that it is our Sector that be showcased.

Social and Emotional Wellbeing

The inaugural Social and Emotional Wellbeing Workforce Support Unit (WSU) Forum was held in Melbourne from April 21st–22nd 2010. In attendance were some of the Social and Emotional Regional Centres that have previously provided support to Bringing Them Home, SEWB and Link-Up workers. These organisations are now in the process of becoming Workforce Support Units. The training aspect of this measure is being implemented through identified Registered Training Organisations.

The workforce support units have the following roles:

1. Co-ordinating a national network to provide professional support to SEWB workers;
2. Ensuring adherence to operational standards: staff supervision, qualifications and mentoring;
3. Supporting best practice service delivery;
4. Co-ordinating delivery of nationally recognised qualifications; and
5. Promoting ongoing training and continuing education.

NACCHO has concerns regarding who will co-ordinate the network nationally and what authority they will have over individuals and or services.

Health Workforce Australia Clinical Placements Proposal (HWA)

Health Workforce Australia sought proposals for 'Clinical Training Funding for Student Growth and Expanding Clinical Training Capacity'. The proposal was designed to provide financial support to the clinical placement of students under agreements between education providers and clinical services providers.

NACCHO has submitted a proposal to attract funding to build the capacity of member RTOs and is awaiting the outcome.

REPORTING ON STRATEGIC PRIORITIES: A MORE EFFICIENT AND EFFECTIVE SECRETARIAT

A core NACCHO activity is to support Member Services and Affiliates. NACCHO assists with supporting several networks for Affiliates and members.

Workforce Issues Policy Officers' (WIPO) Network

The Workforce Issues Policy Officers Network is an active group with face to face meetings, numerous teleconferences, and regular communication via email and phone to address the many workforce issues. Some of the outcomes of the group included:

- Promoting NATSIHWA membership;
- Assisting NACCHO with the jurisdiction COAG workshops as many WIPOs will be actively involved in the working/advisory groups established in each jurisdiction to develop their orientation/training packages;
- Attended the Northern Territory Aboriginal Health Worker Forum;
- Provided information regarding Accreditation and Registration; and
- Presented an overview of the work undertaken by WIPO's nationally.

A priority for the WIPO network is the establishment of Workforce Units within each Affiliate. This is essential given the increase in workforce expansion initiatives such as the introduction of ATSIOW, Healthy Lifestyle Workers, Tobacco Action Workers, COAG Workforce Liaison officers and the myriad of training opportunities that are being offered across all vocations within Aboriginal Health.

Public Health Medical Officers (PHMO) Network

PHMOs within Affiliates are funded by OATSIH to:

- Assist ACCHS to prioritise public health approaches within primary health care;
- Augment the capacity of ACCHS to implement public health initiatives;
- Strengthen service level responses to public health issues such as chronic disease, communicable disease and environmental health; and
- Improve clinical processes and create a culture of quality improvement.

NACCHO contributed to the review of the PHMOs program in July 2009, supporting the role of PHMOs in their jurisdiction. To assist, NACCHO has established the PHMOs electronic forum on the NACCHO website, and posted discussion threads for secure communication. The NACCHO Chair attended the November 2009 forum of the PHMOs to assist NACCHO to progress discussion on nKPIs.

The Review recommended OATSIH work together with the PHMO Network to develop 'formal information sharing activities' to 'respond to the government's policy agenda' and the development of a 'PHMO National Action Plan'. OATSIH has been informed it has an

obligation to engage with the elected Aboriginal leadership (NACCHO Board of Directors) when seeking responses to the government's agenda on national matters.

The NACCHO Secretariat also uses a broader network for public health and medical technical advice on national health policy. The network now includes over 30 doctors with long-standing expertise within our member services (plus the Affiliate PHMOs). This is an informal network and has proven extremely useful in supporting national matters within the Secretariat.

National Aboriginal Information Communication Technology / Information Management (ICT/IM) Reference Group

This period has seen liaison with Affiliates' ICT/IM Officers in strengthening the National Aboriginal ICT/IM Reference Group and identifying topics affecting the sector at both a service and jurisdictional level. This has been undertaken by site visits, telecommunications and a two-day reference group meeting in Canberra in mid February and a number of other face to face meetings.

Outcomes of these meetings include the coordination and development of a National Aboriginal ICT/IM Strategic Framework. It will provide a platform whereby the sector is able to outline the key activities being identified and undertaken within the sector to ensure the issues and challenges being experienced by services and sector are outlined and promoted to government and industry. As a network we have also discussed shared communications and intelligence for Affiliates on issues such as Patient Information Recall Systems, Accreditation and ICT/IM Standards and Compliance to ensure our services are not disadvantaged in comparison to mainstream health industry.

NACCHO has met with OATSIH in relation to the needs of the sector regarding ICT/IM and lobbied for their support in providing resources to enable the Reference Group to meet both independently and with representatives of Department of Health and Ageing.

NACCHO also provided advice to OATSIH about the challenges affecting members, in particular the infrastructure and investment required to improve services' capabilities to address issues arising from the COAG National Aboriginal Health Partnerships Agreements.

Other work with external stakeholders during this period included the following:

- Reviewing information and documentation being developed by National E-Health Transition Authority (NeHTA) regarding the requirements for ICT/IM as part of the whole of government and health industry approach to information technology;
- Informing NeHTA of the ICT/IM Reference Group and to recognise the reference group as a key stakeholder as part of their broader stakeholder consultation mechanism established to provide advice and support on specific program areas; and
- Discussions with representatives from Royal College of Australian General Practice (RACGP) regarding information technology and initiatives being considered by them and if there are opportunities to include the ICT/IM reference group if and when appropriate; and Advocating on behalf of the Affiliates and members to PIRS vendors on the issues being raised that impact on the viability and usability of these systems by Aboriginal Health Services.

NACCHO House

In March, the NACCHO secretariat moved in Canberra from Braddon to a refurbished office in the city. The new office allows NACCHO to accommodate more staff and provide upgraded information technology to more efficiently and effectively deliver the secretariat's services.

AH&MRC's Melinda Bell with daughter Jorja and James Ward of the National Centre in HIV Epidemiology and Clinical Research.

The karaoke performance that won NSW second place.

Graeme Cooper, Ord Valley Aboriginal Health Service, Yvonne Buza NACCHO Board member from SA and Roger Williams from NSW AH&MRC judging the karaoke.

Frank Stanton and Joanne Delaney from Aboriginal Medical Service Western Sydney with NACCHO's Dea Delaney Thiele and Irene Peachey.

Karaoke winners South Australia humbly accept their trophies.

NACCHO Board Members Stephanie Bell NT and Julie Tongs ACT.

NACCHO'S 2009 ANNUAL GENERAL MEETING

NACCHO's Annual General Meeting in mid November for the over 150 ACCHSs across urban, regional and remote Australia was the largest national gathering of Aboriginal People involved in local community health.

Over 200 representatives from their services along with representatives of their NACCHO State and Territory peak bodies were in Darwin this year on Larrakia land for the AGM which was also co-hosted by our local Member service the Danila Dilba Aboriginal Medical Service.

The AGM included the election of the NACCHO Chairperson Justin Mohamed and Deputy Chair Glenda Humes for two year term. There were also reports from our State and Territory Affiliates and for the first time an address by Warren Snowdon, the Minister responsible for Aboriginal and Torres Strait Islander health.

Chair justin Mohamed with outgoing Chair Dr Mick Adams.

Mary Pitts from Riverina Aboriginal Dental/Health Service – Wagga Wagga Phyllis Freeman and Sonia Piper both from Brungle Health Aboriginal Corporation.

Justin Saunders presenting a session on the Institute for Urban Indigenous Health Brisbane.

From the Kimberley, Chris Bin Kali, John Green, Teresa Sibosado and Phillip Matsumoto.

From Rumbalara AC Petah Atkinson and Rochelle Pattern with Jimmy Little, and Neville Atkinson and Lynette Sailor from Gunditjmara Co-op Warrnambool.

Rod Jackson VAHS, Justin Mohamed and Lyn McInness NACCHO Board Member for Victoria.

The Members' meeting included forums on the Close the Gap campaign, establishing a partnership with government, improving the COAG Aboriginal health initiatives, workforce initiatives and improving access to medicines.

On the social side of the event the annual Karaoke Cup sing off between the States and Territories was won by South Australia with NSW being awarded second place. The final decision caused some confusion amongst the finalists but SA in the end were more than happy to accept the Karaoke Cup for the second time in three years. The Northern Territory was a very pleased third.

A moving highlight on the Thursday was a performance by Jimmy Little in support of the launch of the Zaidee's Rainbow Foundation poster campaign promoting organ donation awareness in the Aboriginal community. Jimmy who has received a kidney transplant was just back from Arnhem land communities promoting his foundation's "thumbs up for healthy tucker" message

STATE AND TERRITORY AFFILIATE REPORTS

West Australian Affiliate

Aboriginal Health Council of West Australia (AHCWA)

During April 2010, the Western Australian Government announced allocations of over $115million for 'Closing the Gap' in Aboriginal health. The allocations were developed in partnership between State and Commonwealth Governments, Aboriginal Community Controlled Health Services and Divisions of General Practice. Allocations have been made in areas of addressing chronic disease, healthy lifestyle, reducing smoking, child and maternal health and mental health, including emotional and social wellbeing. Over 40 per cent of funding has gone to our services, and a key outcome is also a new Aboriginal health workforce of near 400.

AHCWA has had an excellent year with the development of a consensus model where the Aboriginal health sector no longer acts in an internally competitive manner.

The first of its kind in Australia, AHCWA led the way in developing the Council of Australia Governments' (COAG) Technical Team to identify key areas of Aboriginal Health in WA requiring improvement. Team members came from around the state, and investigated areas where funding should be channelled. The process enabled a unified approach across WA to:

- identify existing health service delivery;
- mapping of local health priorities;
- development of service partnerships to coordinate care and resources;
- identification of primary care health service gaps; and
- plan accordingly.

The package has enabled the WA Aboriginal Community Controlled Sector to increase its capacity to provide additional, and in some regions, new services, with positions being advertised in coming months. AHCWA RTO staff developed an orientation program to support the induction of the new COAG workforce into the Aboriginal health environment.

In another first for Western Australia, AHCWA staff completed a 'Strengths and Needs' analysis in the area of maternal and child health care. The program received one-off funding from the Department of Health and Ageing WA to establish a maternal and child health program for its member Aboriginal Community Controlled Health Services (ACCHSs). The funding was used to develop models of excellence in maternal and child health care in a select number of ACCHSs in WA. Three pilot centres of excellence were established, and AHCWA is aiming to secure funding to roll out the next stage of this excellent program.

Additionally, the program to design the Beyond the Big Smoke training course has been extended, providing support for yet another crucial Aboriginal health initiative.

In other key highlights this year, AHCWA's Training and Development Centre had its first graduation in the Pilbara in October. Since then, 25 students have graduated in the areas of primary health care and frontline management, and another 22 receiving a Certificate of Attainment.

AHCWA's 2010 Quality Improvement Workshop was held during May and attended by a range of OATSIH funded services from across WA. The focus of the workshop was to provide quality information for accreditation, and the program included an interactive workshop, guest speakers from Medicare, RACGP, DoHA, OATSIH, AGPAL, AVANT, QMS, and AHCWA provided presentations and information to participants. AHCWA hopes to see many services accredited in the near future.

Influential leaders from the Western Australian health industry were brought together at AHCWA's very successful 2010 annual Aboriginal Community Controlled Health Sector Conference and Member's Planning Day in March. Member AMSs shared some successful project stories providing an excellent networking environment. The member services selected what they considered to be the priority demands for AHCWA over the next 12 months.

A new financial model has been developed that has been supported by the Commonwealth Government, who are allowing AHCWA to globalize their PCAP funding. We are in the process of securing funding to sustain AHCWA and to ensure the provision of our core business, which is to provide support to member services. This remains our long term challenge.

Moving into new premises at Dilhorn House in East Perth last year has provided AHCWA staff with a larger, more professional office environment which has enhanced the way we do business.

South Australian Affiliate

Aboriginal Health Council of South Australia (AHCSA)

AHCSA has 19 Member Services and the AGM for 2009 was held in Adelaide in February 2010 (due to Sorry Business), followed by the first Board meeting for 2010. The main issues/activities were:

- Continued partnership and liaison with Country Health SA and the Aboriginal Health Directorate;
- South Australian Aboriginal Health Partnership continues to grow stronger with the signing a new Framework Agreement in 2010 for another five years;
- AHCSA continues to be a member of the COAG Implementation Advisory Group which comprises SA Health, Dept Health and Ageing, GPSA and Rural Doctors Workforce Agency;
- We have been working with Oxfam to progress the signing of the Statement of Intent for South Australia and expect this to happen in the latter part of 2010;

- Several other issues that will be a major focus in the next year will be the review of the AHCSA Constitution, development of our new Strategic Plan, review of the AHCSA Policy Document and organizational accreditation for AHCSA;
- AHCSA continues the focus on strengthening and consolidating our relationships and partnerships with external stakeholders;
- The Aboriginal Primary Health Care Workers Forum is held three times per year – all AHWs participate, whether they work in mainstream or ACCHS;
- The Aboriginal Health Research Ethics Committee meets monthly;
- The Eye Health Specialist Support Coordinator continues to work closely with the Optometrists and Ophthalmologists that travel to rural and remote areas across South Australia supporting health clinics and AHWs in screening and referral. The coordinator also conducts trachoma education for AHW's. This program continues to struggle with a limited budget;
- The Accreditation Support Officer has been supporting AHCSA members to become accredited. Two accreditation workshops were held in the last 12 months: the first event in September 2009 was aimed at introducing accreditation and providing Member Services with an opportunity to share previous experiences; the second event, held on May 2010, provided further information, particularly in the areas of community feedback and ICT/IM programs relating to quality and accreditation;
- The Good Medicines Better Health pilot project officially ended in June 2009, however a continuation of the contract was negotiated with the NPS and AHCSA to work with NACCHO to inform and plan for a national roll-out of the Good Medicines Better Health Course. It has been agreed that there will be funding made available for the delivery of the course in three states of South Australia, Victoria and New South Wales, with a staged roll out to the other states. Funding will be made available for a coordinator in each state to work with member services to facilitate training and support participants in their service.
- In 2009, 18 people graduated with the Certificate IV, and in 2010, 14 others are enrolled. The participants come from regional, remote and urban communities from both interstate as well as from South Australia. Some participants are community members who serve on community services boards or regional Aboriginal Health Advisory Committees, some are Aboriginal Health Workers, youth workers, or research assistants, and some work for government departments and the biggest challenge continues to be with sourcing more funding is securing funding for the Lecturer salary for the course;
- The Aboriginal Maternal Infant Care Program has been designed to help address the need for Aboriginal women to be cared for by AHW's in partnership with midwives. The program has a specific focus on specialised clinical care, related to the wellbeing of the mother and child. An AMIC practitioner will also provide culturally safe social and emotional support during the pregnancy and for several weeks after. To date, AHCSA has delivered several of the core units required for certificate IV, with the remaining units to be delivered throughout the year and continue over into early next year;

- In 2010, there are over 300 students enrolled in AHW training. Much of the training is preparing AHWs to study the Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care – Practice. This qualification will allow AHWs to register as clinical Health Workers in 2012 through the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA);
- The PHMO program continues to provide public health advice and support to AHCSA and member services. An active Public Health Network involving all Aboriginal community controlled health services in SA enables sharing of information across the sector. Areas which have received particular attention over the past year include developing capacity in Information Management; supporting the control of sexually transmitted infections and blood-borne viruses in health services; planning for trachoma elimination; planning a state-wide rheumatic heart disease program; supporting a systematic approach to the management of ear disease; developing CQI activities; oral health issues; GP workforce support; and COAG implementation issues;
- The ATSIHRTONN (Aboriginal and/or Torres Strait Islander Health Registered Training Organisation National Network) is now in its third year of the first 3 year contract. ATISHRTONN was established as a group of Aboriginal and/or Torres Strait Islander Community Controlled Registered Training Organisations designed to build the capacity of its member RTOs to drive education and training delivery to the Aboriginal and Torres Strait Islander health workforce. ATSIHRTONN's Secretariat is auspiced by the Aboriginal Health Council of SA (AHCSA) and comprises a National Coordinator, Senior Project Officer and Administration Assistant. Two face to face network meetings were held during the period; the first in Cairns in September 2009 and the second in Adelaide in February 2010. The meetings were well attended offering opportunities for the Network to share a range of information;
- The Sexual Health Project started in early 2009, and the team has been busy in early 2010 supporting our member services to develop culturally and sustainable sexual and relationship health programs for their services. The program supports the annual Sexually Transmitted Infections (STI) Screening program for 12 weeks beginning April, the development of health promotional resources and coordinated a sexual health workshop in March 2010;
- The Statewide Tobacco Coordinator has visited all of AHCSA member health services from Oak Valley Health Service in the north west to Pangula Mannamurna Inc. in the South East of the State. As well as visited all Aboriginal Health teams within SA Health presenting information on the new Smokefree Policy which was launched on 31 May 2010. Sixty nine staff attended the presentations during this period;
- As part of the COAG Closing the Gap Indigenous Chronic Disease package, AHCSA received funding for an Indigenous Health Project Officer which has been renamed Workforce Liaison Officer. Anna Leditschke was recruited into this role in March 2010.

This will enable AHCSA to take an active role in providing support and state-wide coordination to assist member organisations in implementing the range of Closing the Gap Chronic Disease package measures relevant to the ACCH sector, and to encourage increased cooperation with the Divisions of General Practice network.

- AHCSA continues to work with NACCHO and other Affiliates on the National Health Reform. The AHCSA Board will focus on this at the next meeting in July to develop a South Australian position statement.

New South Wales Affiliate

Aboriginal Health and Medical Research Council of NSW (AH&MRC)

The AH&MRC remains steadfastly committed to achieving health equity for the Aboriginal peoples of New South Wales. To this end, within the broad headings of knowledge, service and leadership, the AH&MRC has supported our members, the Aboriginal Community Controlled Health Services (ACCHS) of NSW, to deliver comprehensive, culturally appropriate primary health care in their respective Aboriginal communities. The uniqueness of ACCHS is well recognised but the importance of the knowledge and experience they engender is not always fully appreciated.

In November 2009, the AH&MRC Directors met with United Nations Special Rapporteur, Professor S. James Anaya, to discuss health and human rights issues confronting Aboriginal communities. A resounding theme of discussions was the failure of governments to work in equal and genuine partnership with Aboriginal people.

Throughout the year, the AH&MRC has brought the knowledge and expertise of the Aboriginal Community Controlled Health Services to bear in discussions around the implementation of the Council of Australian Governments (COAG) Closing The Gap agenda. Given the scale and intensity of the COAG reform agenda, and its objective of achieving health equality and closing the gap in life expectancy, it is critical that planning involves Aboriginal Community Controlled Health Services as partners.

An historic achievement was the signing by the NSW Parliament of the Close the Gap, Indigenous Health Equality, Statement of Intent for NSW, to reduce the difference in life expectancy between Aboriginal and non- Aboriginal Australians within 20 years, recognising that 'crucial to ensuring equal access to health services is ensuring that Aboriginal and Torres Strait Islander peoples are actively involved in the design, delivery and control of these services'.

In an ever changing environment the AH&MRC Secretariat has worked hard to meet the needs of members in organisational support, workforce and accreditation, public health, research, ethics and education. The AH&MRC commends the Secretariat for their work and their decision to work in our sector.

Success has also been made possible by the dedication of our Directors, their good governance providing invaluable wisdom and guidance to the work of the Secretariat, enabling strong Community leadership and strategic focus.

The AH&MRC also has a number of important partners who recognise and embrace the principles of Aboriginal Community Control in Health Service and equal partnership. Without this mutual respect and joining of forces we would have achieved much less and we express our warm thanks to them for sharing our vision for health equity. The AH&MRC also thanks those who have contributed financially thus ensuring the viability of our programs, our activities and our overall achievements as an organisation.

Finally, we thank the members of the AH&MRC, their boards and staff, who see the impact of health inequity every day. The commitment of the AH&MRC to bring the voice of the Aboriginal community to the decision making processes which affect them and to promote the invaluable role of our member's ACCHS will continue to guide our work in the coming year.

Highlights

Aboriginal Eye Care Program reaches 106 Aboriginal Communities

The International Centre for Eyecare Education (ICEE) and AH&MRC Aboriginal Eye Care Program has continued to grow, delivering 3500 eye examinations and providing free spectacles, contact lenses and other vision aids to Aboriginal people in 106 locations including isolated and remote areas. The Regional Aboriginal Eye Health Co-ordinators (AEHC) play a pivotal role in this program. The AH&MRC Aboriginal Health College delivers appropriate training and education for AEHC's and other workers in the field. We are confident that this Program will continue to improve the lives of an increasing number of Aboriginal people in communities throughout NSW.

Statement of Intent signed in Parliament of NSW

On 3rd June 2010, the Parliament of NSW suspended its usual proceedings while the Premier, Kristina Keneally, and the Leader of the Opposition, Barry O'Farrell, addressed the Legislative Assembly and subsequently signed the Close the Gap, Indigenous Health Equality, Statement of Intent for NSW (SOI). The SOI commits governments to work together to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by the year 2030. The SOI was signed by the Chair and the Chief Executive Officer of the AH&MRC and the Members of Parliament of the NSW Legislative Assembly.

SEARCH – Success in urban Aboriginal health research study

The Coalition for Research to Improve Aboriginal Health (CRIAH), between the AH&MRC and the Sax Institute, continues to build capacity in Aboriginal health research as well as conducting research to improve Aboriginal health. The large scale SEARCH (Study of

Environment on Aboriginal Resilience and Child Health) research project, designed to address the significant absence of research on the causes of health and illness in urban Aboriginal children has continued to expand with the total number of Aboriginal children recruited to the study now reaching 1200.

Business Innovations Conference

In September 2009, the AH&MRC held its second ACTION for Health Conference titled Innovations for Business Improvement, funded by the Department of Health and Ageing, providing an important opportunity for ACCHS to discuss and share information about innovations being developed in Aboriginal Community Controlled Health Service and to enable ACCHS to be better informed about the Australian Government's policy developments around Closing the Gap in Indigenous Disadvantage.

Living Better Longer: Chronic Disease Conference

In June 2010, the AH&MRC held its first Aboriginal Chronic Disease Conference titled Living Better Longer: Chronic Disease Conference for Aboriginal Community Controlled Health Services, NGOs and mainstream services working in Aboriginal health. The Conference, funded by NSW Health, focused on holistic approaches to chronic disease that is prevention, treatment and healing, including that of the Aboriginal health workforce, in the areas of renal health, cardiovascular disease, cancer, tobacco resistance, lupus and arthritis, palliative care, diabetes, oral health and social and emotional health and wellbeing.

Let's Talk Gambling Website

In April 2010, the AH&MRC launched the Let's Talk Gambling Website, funded from the Responsible Gambling Fund, Office of Liquor Gambling and Racing, to respond to the needs of Aboriginal communities by providing relevant information and resources about responsible gambling and support available for people affected by problem gambling. To our knowledge, this is the first Aboriginal specific website with information about gambling in Australia.

Aboriginal Health College Graduation

In March 2010, another 99 students graduated from the Aboriginal Health College at Little Bay in a range of courses at Certificate III, IV and Diploma level. The Aboriginal Health College commenced work on articulation arrangements with two major universities.

BREATHE and A-TRAC Tobacco Cessation Program

Building on the knowledge and experience gained during the BREATHE (Building Research Evidence to Address Aboriginal Tobacco Habits Effectively) research project, the AH&MRC has commenced the development of a significant tobacco control program. The A-TRAC (AH&MRC Tobacco Resistance and Control) Program will focus on supporting the ACCHSs, workforce development and training, social marketing, monitoring and evaluation and policy development and co-ordination to address this important issue.

Victorian Affiliate

Victorian Aboriginal Community Controlled Health Organisation (VACCHO)

It has been a progressive year for VACCHO and its members and community.

To better support our members, VACCHO has been actively visiting the regions and consolidating data to build member's profiles. We hope to use these profiles to identify areas where VACCHO can better support our members. VACCHO endeavours, with our members, to build our knowledge and receive recognition for the unique knowledge that VACCHO, the members and the community are custodians of.

VACCHO offers support networks for the development and delivery of strategies and the development of workforce capacity in areas including Koori Maternity Services, Palliative Care, Accreditation, SEWB, Sexual Health, Drug and Alcohol, Koori Health Liaison Officers.

This year VACCHO had a strong focus on equal and respectful partnerships. VACCHO remains a key member of the Victorian Advisory Council of Koori Health and continues to facilitate the Coalition of the Intentional in pursuit of the CTG commitments. We now have 23 Memorandum of Understandings including two new MOU's with the Pharmaceutical Guild of Australia and Monash University. This year has also witnessed building more solid partnerships with our members, ACCHO's, VCOSS and the mainstream. We intend to continue building strong links with the government, research and public health sectors and look forward to maintaining these relationships of equality and respect, while making mainstream organisations accountable for Aboriginal community outcomes and Aboriginal funding.

Major changes are occurring in the health sector at a national level. We have ensured that VACCHO have been at the forefront of the national policy agenda, advocating on behalf of its members for issues relating to the Health Reform and Closing the Gap. We have voiced the shortcomings of such policies and highlighted the implications they could have on the health of our Aboriginal communities, and continue to work to improve the roll out and implementation process.

As VACCHO and its Members rejoice about the marked growth and change this year has brought, we also share the unyielding pressures including infrastructure to accommodate such expansion. VACCHO has experienced significant growth in terms of staff, programs and responsibility. In particular, this year our health programs for smoking, physical activity and nutrition, SEWB, Koori Alcohol Action Plan, Koori Maternity Services and Drug and Alcohol have expanded at a considerable rate. While always challenging, VACCHO continues to strive for improved strategies, coordination and evaluation processes for these programs.

We have also had significant developments in our Research Unit. We commend the program on their notable efforts to produce the Social Determinants of Aboriginal Health Report. I have no doubt such an excellent resource will inform and guide those within the sector and beyond. The knowledge that VACCHO and its Members possess of Aboriginal Victorian communities is invaluable and continuously sought after. Accordingly, VACCHO

often has had input into university research such as Heart Health. It should always be the community that drive the research priorities and the community, to which the research transfers to, resulting in improved Koori health.

Tasmanian Affiliate

Tasmanian Aboriginal Centre

During the past year the Tasmanian Aboriginal Centre has continued its work in seeking redress for injustices wherever they appeared and pushed for the rights of Aboriginal people to control our own futures. We marched through the streets of Hobart to parliament house on 26th January pushing for the date of Australia day to be changed from celebrating the first white invasion of our lands to a more appropriate day.

We campaigned vigorously against a four lane highway being built over one of the oldest Aboriginal heritage sites in the southern hemisphere. We received widespread support from the white community and media but the state government has not budged in its commitment to destroy this site at Brighton. Approaches to the Federal government are continuing as are appeals to the court. We did however make some inroads in bringing about better consultation processes between government and the Aboriginal community where there are proposals to development projects on or near Aboriginal sites. The lack of effective federal Aboriginal heritage legislation makes our job more difficult.

We continued to object strongly to the way Aboriginal health money is now being used to provide services to white families in their so called Indigenous child and family centres which are open to all. And have struggled to get money to run our own parenting and children's services, all the while watching funding flowing to white groups. We watched in dismay as our rights to self determination were further whittled away by governments funding white groups to deliver Aboriginal services. In the health area we are concerned that the Close the Gap targets will be met by policies and guidelines that support more white people to identify as Aboriginal in claiming health services and thus distort statistical reporting potentially showing health improvements that do not actually take place.

But apart from all the protesting and objecting that we do, we have had time to be an effective NACCHO affiliate and deliverer Aboriginal primary health care services. As such we have been involved in various consultations, research, partnership development, tendering processes and so on, and always battling against the odds to try to ensure that Aboriginal money is used where it is most needed, to increase the capacity of Aboriginal community controlled services to respond to the health needs of our community.

Northern Territory Affiliate

Aboriginal Medical Services Alliance Northern Territory (AMSANT)

AMSANT celebrated its 15th birthday in 2009 amidst an extraordinarily busy year—both on the ground with our membership, as well as at the jurisdictional and national level.

Foremost has been our work out bush in building towards establishing Aboriginal control over comprehensive primary health care across the regions in the Northern Territory. It has been slow, exacting work requiring considerable community-based discussion and consultation. The process reflects the document Pathways to community control which was launched in November 2009. Pathways has been developed over a long period through the Northern Territory Aboriginal Health Forum, a partnership between AMSANT and the Commonwealth and Northern Territory governments.

At the heart of regionalising has been the work of the Reform and Development Unit [RaDU] which has averaged nearly one a week of major consultative meetings from the Top End to the desert. Limited resources have meant the major efforts have been towards East Arnhem, in which Miwatj Health has a leading role; West Arnhem through the Red Lily Interim Health Board and Anyinginyi Health in Tennant Creek which is looking to nurture regional approaches to Primary Health Care in the Barkly. Advances have also been made in central Australia through on-the-ground consultations and large scale meetings. The likely outcome of this is that there will be three Health Service Delivery Areas moving towards regional Aboriginal control in coming years, with organizations in Alice Springs, central West and Central East.

The aftermath of the Intervention in the Northern Territory is still with us, and we have responded to proposed changes to the legislation imposed on the Northern Territory in 2007. We remain critical of those elements of the Intervention for which there is little or no evidence as to benefit for Aboriginal Territorians—with a particular emphasis on the restoration of the Racial Discrimination Act, and the negative effects of the mandatory, universal nature of income quarantining and management.

Nevertheless, the increased resources to comprehensive primary health care made available as part of the Intervention—the Expanded Health Service Delivery Initiative [EHSDI]—is allowing substantial reform of health delivery in the Territory. As well as increased resources in absolute terms, funding to Aboriginal primary health care is now distributed far more equitably through a per capita funding formula that also takes into account remoteness and disease burden. Based on an agreed set of core services, the existing and developing regional health services will have greater flexibility in developing health programs appropriate to the particular circumstances of our regions.

Parallel with increased physical resources, our sector has also worked hard at developing a series of 19 Key Performance Indicators [NTAH KPIs]. These have been designed as a tool to reflect the activities of our services, and analyse the results they are achieving. By 2010-2011 it is expected the collection of the KPIs will be rigorous and extensive enough to allow system-wide analysis of the Comprehensive Primary Health Care sector in the Northern Territory. Based on such evidence, each of our services will be much better able to plan and run services to their members, from our cities and towns to our most remote clinical settings.

In addition, the financial year saw AMSANT undertaking a major push into Continuous Quality Improvement [CQI] becoming a fundamental practice across the entire Primary

Health Care sector—including in clinics currently run by the NT Department of Health and Families [DHF]. With coordinators in Alice Springs and Darwin, CQI facilitators are being trained across the Territory, and are set to transform the way business is done in all clinical settings in the Territory.

A highlight of the year was the mounting of the Fresh Food Summit in Tennant Creek in May. Over 300 people attended from across the Territory—from community members to Aboriginal Health Workers and other clinicians to public servants to representatives of community stores. A DVD of the proceedings will be available early in the new financial year.

The year also saw substantial moves to reform of the whole health system coming from the Australian Government following the Preventive Health Task Force and the Health and Hospitals Reform Commission. The reforms proposed across prevention and Primary Health Care largely reflect the learnings and experience of the Aboriginal community-controlled sector over the last four decades—so in many ways were of little surprise. However, AMSANT has maintained a firm line that the proposed Primary Health Care Organisations—sometimes called Medicare Locals—should be funds holders and not services providers, and that furthermore the Northern Territory should see an Aboriginal Primary Health Care Organisation quite separate from the Divisions of General Practice, which have historically had little interest in or knowledge of Aboriginal Comprehensive Primary Health Care. This issue will continue well into the coming financial year.

Our AGM this year saw constitutional changes which look to the future of the whole Aboriginal health sector in the Northern Territory. In particular, our membership is now set to expand through affiliate membership of AMSANT. This will allow membership to Aboriginal controlled health related organisations in the Northern Territory whose core work does not include Primary Health Care delivery, but who have a commitment in their activities to the philosophy and principles behind our work.

Australian Capital Territory Affiliate

Winnunga Nimmityjah Aboriginal Health Service

In 2009-10 the Winnunga Nimmityjah Aboriginal Health Service CEO Ms Julie Tongs represented Winnunga on the ACT Aboriginal Health Forum and many other ACT and national committees. The CEO also attended NACCHO Board meetings and provided ongoing input into NACCHO national policy.

The ACT Chief Minister, the Winnunga Board Chairperson, the Winnunga CEO and other stakeholders, signed the ACT Close the Gap Statement of Intent at Winnunga in April 2010.

The Public Health Medical Officer (PHMO) represented Winnunga on ACT committees in chronic disease, primary care and influenza. The PHMO co-ordinated the Winnunga response to the influenza pandemic in 2009 and in 2010 worked on implementation of COAG Closing the Gap measures including the PIP and PBS co-pay components. The PHMO continues to provide support on clinical quality improvement, data analysis and reporting,

health promotion including smoking cessation and GP education. The PHMO works with ACT Health on public health issues and with the national PHMO network to discuss issues common to all jurisdictions. The PHMO has an academic appointment with the ANU to support supervision of student research at Winnunga.

The Winnunga Data Officer has participated in the national ICT State Coordinators Network with the aim of discussing, generating ideas, sharing learning and making recommendations on ICT, IM, PIRS and reporting issues. The Data Officer has supported implementation of the COAG Closing the Gap measures and has worked with local health agencies to improve electronic transfer of medical information. In addition, she has provided Communicare training, data extraction and analysis, six monthly reporting and improved Medicare claiming. The Data Officer also conducted some support visits to the Riverina Medical and Dental Aboriginal Corporation in Wagga Wagga.

The Workforce Information Policy Officer has been working on the implementation of the workforce priorities from the Winnunga Business Plan 2007–2012. In October 2009 Winnunga commenced a workforce development scoping project. This scoping project will inform the process for a Training Needs Analysis (TNA) which will enable Winnunga to identify workforce development needs in line with current and future demand. The TNA will also identify appropriate skills clusters to sustain professional development and enhance career pathways.

Winnunga has entered into two auspicing arrangements to provide training to staff and to meet the 2012 National Registration requirements for Aboriginal Health Workers. Arrangements have been put in place with the Aboriginal Health Council of South Australia and with the Canberra Institute of Technology.

A workforce working group, an initiative of Winnunga, has been formed as a sub-group of the ACT Health Forum. This group facilitates implementation of workforce strategies developed by the ACT Health Forum and is attended by the Winnunga Workforce Information Policy Officer. The Workforce Information Policy Officer also provides ongoing information to staff on the National Registration and Accreditation Scheme for Health Professionals and the National Aboriginal and Torres Strait Islander Health Worker Association.

Winnunga was successful in obtaining funding for 10 places under the national Enterprise Based Productivity Places Program managed by the national Community Services and Health Industry Skills Council. These funds will be used to train relevant staff to obtain the Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice).

Queensland Affiliate

Queensland Aboriginal and Islander Health Council (QAIHC)

Overview

The 2009/2010 period has brought about important change and progression for QAIHC and the Community controlled health sector in Queensland. A number of organisational

changes and restructures have been undertaken against a backdrop of health policy reforms, to ensure the ongoing strength and stability of the organisation and its Member services within the context of an ever-changing policy environment.

Key internal changes include formation of three principal organisational units, through which QAIHC's core business functions are now delivered. This includes Corporate Services, Sector Development and the Preventative Health Unit.

There is a retained focus across these action areas on enabling improved delivery of support services to QAIHC's 27 Member organisations, to ensure a strengthened and continually progressive community controlled health sector. The function of these units will also be critical to enabling the achievement of core objectives contained within the amended QAIHC Strategic Plan, which sets out key actions to be undertaken over the next three years.

Sector reform

QAIHC is focused on achieving health reform in Queensland that enables greater access to health care for Aboriginal and Torres Strait Islander Australians and which continues to close the gap in health disadvantage. Delivery of high quality evidence-based primary health care services is critical for this to occur, and QAIHC is committed to providing support and capacity to its Membership to enable realisation of this core objective.

Moves toward establishing innovative models of health care that are regionally and collaboratively coordinated, but locally and responsively-delivered, signifies a further target for the community controlled sector in Queensland and QAIHC has already commenced work with services and other peak bodies to enable this process to occur.

Cornerstone documents and support materials that coincide with and support these objectives have been developed and are in the process of being implemented throughout Queensland, to ensure a sustainable and united sector reform process, which closes the gap in Aboriginal and Torres Strait Islander health disadvantage.

There is a need to stay in-step with the health reform agenda to ensure the Community controlled health sector remains at the forefront of health planning and service delivery in Queensland and that there is a retained focus on Closing The Gap in health outcomes. QAIHC and its core business units are committed to this end and the work that has been undertaken to date, and which is planned for the proceeding 12 months and beyond, reflects this underlying objective.

Service development and QAIHC support services

In addition to supporting services through this change period, both the Sector Development and the Preventative Health units have been engaged with Member Services to enable continual improvements in internal processes and service delivery across a number of key areas.

The sector development team has been focused on developing workforce strategies and initiatives, which target building strength and capacity within the sector and among health workers and providers. Strategies spanning the spectrum of training, recruitment, retention and up-skilling are continually being implemented, reviewed and updated to ensure an ongoing progressive and improving sector that is underpinned by a strong and qualified workforce, which is capable of actively and appropriately responding to the health needs of Aboriginal and Torres Strait Islander clients.

Work to build and extend on service and sector development via implementation of revised internal practices pertaining areas, such as management and governance, are also being undertaken and will be critical over this upcoming period of change to achieve regionalisation and greater levels of inter-service and inter-sector collaboration.

The role of the preventative health unit in planning and coordinating the implementation of various health promotion strategies and activities has also been of particular importance in terms of widening the scope of tools and resources available to Member services and their health promotion staff, which can be used as part of local campaigns and health initiatives. Continued efforts in this area are critical to building capacity to deliver improved primary health care services that are evidence-based and which encourage new and innovative ways of connecting with community to convey important health promotion messages that achieve preventative and protective outcomes.

Participation in quality improvement programs, including the Australian Primary Care Collaboratives (APCC), has been another avenue through which the unit has been engaged with Members, with 15 services participating in this program to promote ongoing quality improvement and implementation of system-wide changes to better service delivery and health outcomes for their client populations. These efforts complement and coincide with the work of the sector development unit to support services in implementing and activating improved systems and processes to achieve accreditation.

QAIHC itself, with the support of the committed efforts of Corporate Services, are also undertaking to achieve accreditation under ISO. Internal steps to enable reduced risk and enhanced support for staff and Members have also been implemented and will continue to be revised and adjusted accordingly.

Conclusion

These broad summaries of QAIHC's activities over the 2009-2010 period indicate the significant efforts undertaken to ensure the continuing growth and expansion of the Queensland community controlled sector in a manner that will best enable improved health outcomes for Aboriginal and Torres Strait Islander Australians.

There is a critical need to maintain and extend on support services for our Members, to ensure these efforts continue and that community controlled services remain at the forefront of health planning and service delivery for Aboriginal and Torres Strait Islander people now and into the future.

National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

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National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

DIRECTORS' REPORT

Your directors present their report on the company for the financial year ended 30 June 2010.

Directors

The names of the directors in office at any time during or since the end of the financial year are:

Justin Mohamed (Elected Chairperson November 2009)

Glenda Humes (appointed Deputy Chairperson November 2009)
Lynn McInnes
Stephanie Bell
Yvonne Buza
Julie Tongs
Phillip Matsumoto
Elizabeth Adams
Christine Corby
Paula Arnol
Sheryl Lawton
Valda Keed
John Singer
Mick Adams (ceased November 2009)
June Sculthorpe (ceased October 2009)
Raylene Foster (appointed October 2009)
Alan Brown (ceased December 2009)
Andrew Gardiner (appointed December 2009)
Lorraine Whitby (appointed March 2009)

Directors have been in office since the start of the financial year to the date of this report unless otherwise stated.

Operating Results

The company's operating result for the financial year was a surplus of $2,396 (2009: deficit of $71,753).

Review of Operations

A review of the operations of the company during the financial year and the results of those operations found that during the year, the company continued to engage in its principal activity, the results of which are disclosed in the attached financial statements.

National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

Significant Changes in State of Affairs

No significant changes in the state of affairs of the company occurred during the financial year.

Principal Activity

The principal activity of the company during the financial year was to act as the national umbrella organisation representing Aboriginal Community Controlled Health Services relating to Aboriginal health and well being. This comprises the running of the National Secretariat and the provision of secretarial services to the National Executive Committee and the full membership. No significant change in the nature of these activities occurred during the year.

After Balance Date Events

No matters or circumstances have arisen since the end of the financial year which significantly affected or may significantly affect the operations of the company, the results of those operations, or the state of affairs of the company in future financial years.

Likely Developments

The company expects to maintain the present status and level of operations and hence there are no likely developments in the company's operations.

Environmental Issues

The company's operations are not regulated by any significant environmental regulation under a law of the Commonwealth or of a State or Territory.

Dividends Paid or Recommended

No dividends were paid or declared since the start of the financial year.
No recommendation for payment of dividends has been made.

National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

Meetings of Directors

DIRECTORS	DIRECTORS' MEETINGS	
	Number eligible to attend	Number attended
Mick Adams (ceased November 2009)	2	2
Justin Mohamed (Elected Chairperson November 2009)	4	4
Stephanie Bell	4	4
Lynn McInnes	4	4
vonne Buza	4	4
Julie Tongs	4	3
Phillip Matsumoto	4	4
Elizabeth Adams	4	4
Christine Corby	4	2
Paula Arnol	4	2
June Sculthorpe (ceased October 2009)	1	1
Raylene Foster (appointed October 2009)	3	3
Sheryl Lawton	4	4
Valda Keed	4	4
John Singer	4	2
Alan Brown (ceased December 2009)	2	2
Lorraine Whitby	4	4
Andrew Gardiner (appointed December 2009)	2	2
Glenda Humes (appointed Deputy Chairperson November 2009)	2	2

Indemnification of Officer or Auditor

No indemnities have been given or insurance premiums paid, during or since the end of the financial year, for any person who is or has been an officer or auditor of the company.

Proceedings on Behalf of the Company

No person has applied for leave of Court to bring proceedings on behalf of the company or intervene in any proceedings to which the company is a party for the purpose of taking responsibility on behalf of the company for all or any part of those proceedings.

The company was not a party to any such proceedings during the year.

National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

Auditor's Independence Declaration

A copy of the auditor's independence declaration as required under section 307C of the Corporations Act 2001 is set out on page 76.

Signed in accordance with a resolution of the Board of Directors:

Director: Justin Mohamed

Director: Lynn McInnes

Dated: 24 August 2010

National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

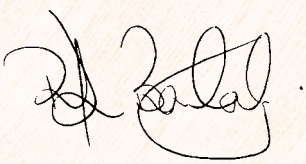
AUDITOR'S INDEPENDENCE DECLARATION

AUDITOR'S INDEPENDENCE DECLARATION UNDER SECTION 307C OF THE CORPORATIONS ACT 2001 TO THE DIRECTORS OF NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION

I declare that, to the best of my knowledge and belief, during the year ended 30 June 2010 there have been:

- no contraventions of the auditor independence requirements as set out in the Corporations Act 2001 in relation to the audit; and
- no contraventions of any applicable code of professional conduct in relation to the audit.

PKF Di Bartolo Diamond and Mihailaros



Ross Di Bartolo
Partner

Dated: 24 August 2010

National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

FINANCIAL REPORT

Statement of Comprehensive Income

For the year ended 30 June 2010

	Notes	2010 $	2009 $
Revenue from ordinary activities	2	**4,294,220**	3,332,253
Employee benefits expense		**(2,157,931)**	(2,078,984)
Depreciation and amortisation expenses	2	**(28,708)**	(24,916)
Other expenses from ordinary activities	2	**(2,105,185)**	(1,300,106)
Profit from ordinary activities		**2,396**	(71,753)
Other comprehensive income			
Net gain / (loss) on revaluation of non-current assets		**-**	-
Total comprehensive income		**-**	-
Total comprehensive income / (loss) attributable to members		**-**	-
Profit / (loss) attributable to members		**2,396**	(71,753)

National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

STATEMENT OF FINANCIAL POSITION

For the year ended 30 June 2010

	Notes	2010 $	2009 $
CURRENT ASSETS			
Cash and cash equivalents	3	**617,496**	399,267
Receivables	4	**1,612,897**	193,704
Other	5	**100,304**	22,746
TOTAL CURRENT ASSETS		**2,330,697**	615,717
NON CURRENT ASSETS			
Property, plant and equipment	6	**113,100**	86,617
TOTAL NON CURRENT ASSETS		**113,100**	86,617
TOTAL ASSETS		**2,443,797**	702,334
CURRENT LIABILITIES			
Payables	7	**404,078**	207,155
Financial Liabilities	8	**43,612**	40,901
Provisions	9	**247,913**	169,311
Other	10	**1,564,660**	103,829
TOTAL CURRENT LIABILITIES		**2,260,263**	521,196
NON CURRENT LIABILITIES			
Provisions	9	**-**	-
TOTAL NON CURRENT LIABILITIES		**-**	-
TOTAL LIABILITIES		**2,260,263**	521,196
NET ASSETS		**183,534**	181,138
EQUITY			
Retained profits		**183,534**	181,138
TOTAL EQUITY		**183,534**	181,138

National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

STATEMENT OF CHANGE IN EQUITY

For the year ended 30 June 2010

	Retained Earnings	Total Equity
	$	$
Balance at 1 July 2008	**252,891**	252,891
Net Surplus/(Loss) for the year	**(71,753)**	(71,753)
Balance at 30 June 2009	**181,138**	181,138
Balance at 1 July 2009	**181,138**	181,138
Net Surplus/(Loss) for the year	**2,396**	2,396
Balance at 30 June 2010	**183,534**	183,534

National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

STATEMENT OF CASH FLOWS

For the year ended 30 June 2010

	Notes	2010 $	2009 $
CASH FLOW FROM OPERATING ACTIVITIES			
Receipts from customers		**61,053**	79,810
Operating grant receipts		**4,831,669**	3,437,075
Payments to suppliers and employees		**(4,635,356)**	(3,962,827)
Interest received		**16,947**	29,678
Net cash provided by/(used in) operating activities	14(b)	**274,313**	(416,264)
CASH FLOW FROM INVESTING ACTIVITIES			
Proceeds from sale of property, plant and equipment		**19,000**	18,700
Payment for property, plant and equipment		**(75,084)**	(36,405)
Net cash used in investing activities		**(56,084)**	(17,705)
Net increase/(decrease) in cash held		**218,229**	(433,969)
Cash at beginning of financial year		**399,267**	833,236
Cash at end of financial year	14 (a)	**617,496**	399,267

National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2010

NOTE 1: STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

The financial report is a general purpose financial report that has been prepared in accordance with Accounting Standards, Urgent Issues Group Consensus Views and other authoritative pronouncements of the Australian Accounting Standards Board and the Corporations Act 2001.

The financial report is for the entity National Aboriginal Community Controlled Health Organisation as an individual entity. National Aboriginal Community Controlled Health Organisation is a company limited by guarantee, incorporated and domiciled in Australia.

The financial report has been prepared on an accruals basis and is based on historical costs. It does not take into account changing money values or, except where stated, current valuations of non current assets. Cost is based on the fair values of the consideration given in exchange for assets.

Australian Accounting Standards include Australian equivalents to International Financial Reporting Standards (IFRS). Compliance with the Australian equivalents to IFRS (AIFRS) ensures that the financial report, comprising the financial statements and notes complies with IFRS.

The following is a summary of the material accounting policies adopted by the company in the preparation of the financial report. The accounting policies have been consistently applied, unless otherwise stated.

(a) Income Tax

No provision for income tax has been raised as the company is exempt from income tax under Division 50 of the Income Tax Assessment Act 1997.

(b) Property, Plant and Equipment

Each class of property plant and equipment is carried at cost or fair value less, where applicable, any accumulated depreciation.

Property

Freehold land and buildings are measured on the fair value basis being the amount which an asset could be exchanged between knowledgeable willing parties in an arm's length transaction. It is the policy of the company to have an independent valuation every three years, with annual appraisals being made by the directors.

Plant and equipment

Plant and equipment is measured on the cost basis.

The carrying amount of plant and equipment is reviewed annually by the directors to ensure it is not in excess of the recoverable amount from those assets. The recoverable amount is assessed on the basis of the expected net cash flows which will be received from the assets employment and subsequent disposal. The expected net cash flows have not been discounted to present values in determining recoverable amounts.

Depreciation

The depreciable amount of all fixed assets including buildings and capitalised leased assets, but excluding freehold land, are depreciated over their estimated useful lives to the company commencing from the time the asset is held ready for use. Properties held for investment purposes are not subject to a depreciation charge. Leasehold improvements are amortised over the shorter of either the unexpired period of the lease or the estimated useful lives of the improvements.

The depreciation rates and useful lives used for each class of depreciable assets are:

Class of fixed asset	Depreciation rates/ useful lives	Depreciation basis
Office Equipment	3 18 %	Straight Line
Furniture Fixtures and Fittings	9 15 %	Straight Line
Computer Equipment	10 24 %	Straight Line
Improvements	10 24 %	Straight Line

(c) Employee Benefits

Provision is made for the company's liability for employee benefits arising from services rendered by employees to balance date. Employee benefits expected to be settled within one year together with benefits arising from wages and salaries, annual leave and sick leave which will be settled after one year, have been measured at the amounts expected to be paid when the liability is settled plus related on costs. Other employee benefits payable later than one year have been measured at the present value of the estimated future cash outflows to be made for those benefits.

Contributions are made by the company to an employee superannuation fund and are charged as expenses when incurred.

(d) Cash

For the purposes of the Statement of Cash Flows, cash includes cash on hand and at call deposits with banks or financial institutions, investments in money market instruments maturing within less than two months and net of bank overdrafts.

(e) Revenue

Revenue from the rendering of a service is recognised upon the delivery of the service to the customers.

Interest revenue is recognised on a proportional basis taking into account the interest rates applicable to the financial assets.

Other revenue is recognised when the right to receive the revenue has been established.

All revenue is stated net of the amount of goods and services tax (GST).

(f) Goods and Services Tax (GST)

Revenues, expenses and assets are recognised net of the amount of GST, except where the amount of GST incurred is not recoverable from the Australian Taxation Office. In these circumstances the GST is recognised as part of the cost of acquisition of the asset or as part of an item of expense. Receivables and payables in the Statement of Financial Position are shown inclusive of GST.

National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

	2010 $	2009 $
NOTE 2: PROFIT FROM ORDINARY ACTIVITIES		
Profit (losses) from ordinary activities has been determined after:		
(a) Expenses		
- Consultancy fees	**370,852**	88,500
- Loss on disposal of non-current assets	**893**	4,298
- AGM and board meeting costs	**124,970**	102,908
- Meetings, workshops and seminar costs	**282,318**	52,503
- Provision for debtful debts	**-**	25,520
- Rent	**226,700**	124,101
- Telephone	**64,728**	60,758
- Travel expenses	**816,979**	648,754
- other expenses	**217,745**	192,964
	2,105,185	1,300.106
Depreciation of non current assets		
Plant and equipment	**28,708**	24,916
(b) Revenue		
Grant funding	**4,221,770**	3,284,248
Other Income	**55,503**	18,327
Interest Income	**16,947**	29,678
	4,294,220	3,332,253
(c) Auditors Remuneration		
- Audit Services	**13,500**	13,500
- Other Services	**-**	-
	12,000	13,500
NOTE 3: CASH AND CASH EQUIVALENTS		
Cash on hand	**2,829**	1,183
Cash at bank	**575,654**	359,071
Deposits at call	**39,013**	39,013
	617,496	399,267

	2010 $	2009 $

NOTE 4: TRADE AND OTHER RECEIVABLES

CURRENT		
Trade and other debtors	**1,638,417**	219,224
Provision for Doubtful Debts	**(25,520)**	(25,520)
	1,612,897	193,704

(i) Credit Risk — Trade and Other Receivables

The company does not have any material credit risk exposure to any single receivable or group of receivables.

The following table details the company's trade and other receivables exposed to credit risk with ageing analysis and impairment provided for thereon. Amounts are considered as 'past due' when the debt has not been settled within the terms and conditions agreed between the association and the customer or counter party to the transaction. Receivables that are past due are assessed for impairment by ascertaining solvency of the debtors and are provided for where there are specific circumstances indicating that the debt may not be fully repaid to the association.

The balances of receivables that remain within initial trade terms (as detailed in the table) are considered to be of high credit quality.

	Gross Amount	< 30 days	Past Due 31–60 days	Past Due 61–90 days	Past Due > 90 days	Past Due and Impaired
		$	$	$	$	$
2010						
Trade and other receivables	**$1.638,417**	1,508,664	10,000	-	94,233	25,520
2009						
Trade and Other receivables	**$219,224**	148,363	-	400	19,421	25,520

National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

	2010 $	2009 $
NOTE 5: OTHER ASSETS		
CURRENT		
Prepayments	**99,584**	22,746
Other current assets	**720**	-
Total Other Assets	**100,304**	22,746
NOTE 6: PROPERTY, PLANT AND EQUIPMENT		
PLANT AND EQUIPMENT		
(a) Plant and equipment		
At cost	**77,637**	76,366
Less accumulated depreciation	**(63,965)**	(62,232)
	13,672	14,134
(b) Motor vehicles		
At cost	**27,967**	28,715
Less accumulated depreciation	**(120)**	(2,466)
	27,847	26,249
(c) Office equipment		
At cost	**76,219**	67,489
Less accumulated depreciation	**(62,194)**	(57,982)
	14,025	9,507
(d) Computer equipment		
At cost	**211,400**	174,283
Less accumulated depreciation	**(153,844)**	(137,556)
	57,556	36,727
Total property, plant and equipment	**113,100**	86,617

NOTE 6: PROPERTY, PLANT AND EQUIPMENT

(a) Movements in Carrying Amounts

Movement in the carrying amounts for each class of property, plant and equipment between the beginning and the end of the current financial year

	Plant and equipment	Motor vehicles	Office equipment	Computer equipment	Total
	$	$	$	$	$
2010					
Balance at the beginning of the year	14,134	26,249	9,507	36,727	86,617
Additions	1,271	27,968	8,730	37,117	75,086
Disposals	-	(19,895)	-	-	(19,895)
Depreciation expense	(1,733)	(6,475)	(4,212)	(16,288)	(28,708)
Carrying amount at end of year	**13,672**	**27,847**	**14,025**	**57,556**	**113,100**

	2010	2009
	$	$

NOTE 7: TRADE AND OTHER PAYABLES

CURRENT		
Trade creditors and accruals	**128,523**	74,324
Sundry creditors (ATO)	**275,555**	132,831
	404,078	207,155

NOTE 8: FINANCIAL LIABILITIES

CURRENT		
Corporate Credit Cards	**43,612**	40,901

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	Notes	2010 $	2009 $
NOTE 9: PROVISIONS			
CURRENT			
Annual Leave Provision		**182,213**	119,733
Long Service Leave Provision		**65,700**	49,578
Employee benefits	10(a)	**247,913**	169,311
NON CURRENT			
Employee benefits	10(a)	-	-
(a) Aggregate employee benefits liability		**247,913**	169,311
NOTE 10: OTHER LIABILITIES			
CURRENT			
Income in Advance		**1,564,660**	103,829

NOTE 11: RELATED PARTY TRANSACTIONS

The names of directors who have held office during the financial year are:

Justin Mohamed	Elizabeth Adams	Mick Adams (ceased November 2009)
Glenda Humes	Christine Corby	June Sculthorpe (ceased October 2009)
Lynn McInnes	Paula Arnol	Raylene Foster (appointed October 2009)
Stephanie Bell	Sheryl Lawton	Alan Brown (ceased December 2009)
Yvonne Buza	Valda Keed	Andrew Gardiner (appointed December 2009)
Julie Tongs	John Singer	Lorraine Whitby (appointed March 2009)
Phillip Matsumoto		

NOTE 11: RELATED PARTY TRANSACTIONS

Key Management Personnel

Key management personnel comprise directors and other key persons having authority and responsibility for planning, directing and controlling the activities of the organization.

	2010 **$**	2009 $
Key Management Personnel Compensation Summary		
Short Term Employee Benefits	**481,906**	478,176
Long Term Employee Benefits	**14,483**	11,775
	496,389	489,951

NOTE 12: ECONOMIC DEPENDENCE

Economic dependency exists where the normal trading activities of a company depends upon a significant volume of business. The National Aboriginal Community Controlled Health Organisation is dependant on grants received from the Department of Health and Ageing to carry out its normal activities.

NOTE 13: SEGMENT REPORTING

The Company operates in the Community Services Segment.

	2010 $	2009 $

NOTE 14: CASH FLOW INFORMATION

(a) Reconciliation of cash

Cash at the end of the financial year as shown in the statement of Cash Flows is reconciled to the related items in the statement of financial position as follows:

Cash on hand	**2,829**	1,183
Cash at bank	**575,654**	359,071
At call deposits with financial institutions	**39,013**	39,013
	617,496	399,267

(b) Reconciliation of cash flow from operations with profit from ordinary activities after income tax

Loss from ordinary activities after income tax	**2,396**	(71,753)
Non cash flows in profit from ordinary activities		
Depreciation	**28,708**	24,916
Doubtful debts provision	**-**	25,520
Net (gain) / loss on disposal of property, plant and equipment	**893**	4,298
Changes in assets and liabilities		
(Increase)/decrease in receivables	**(1,419,193)**	(23,046)
(Increase)/decrease in other assets	**(77,558)**	(22,746)
Increase/(decrease) in grants received in advance	**1,460,831**	(84,456)
Increase/(decrease) in payables and credit card liabilities	**199,634**	(274,031)
Increase/(decrease) in provisions	**78,602**	5,034
Cash flows from operations	**274,313**	(416,264)

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	2010 $	2009 $

NOTE 15: LEASING COMMITMENTS

(a) Operating leases

Operating leases commitments payable:

- not later than 1 year	353,169	**97,905**
- later than 1 year, but not later than 5 years	953,563	-
Total operating lease liability	1,306,732	**97,905**

NOTE 16: FINANCIAL RISK MANAGEMENT

(i) Financial risk management policies

The company's financial instruments consist mainly of cash and deposits at bank, trade debtors, trade creditors and secured commercial credit facilities. The Board of directors meet on a regular basis to assist the company in meetings its financial targets, whilst minimising potential adverse effects on financial performance. The total of each category of financial instruments, measured in accordance with AASB139 as detailed in the accounting policies to these financial statements, are detailed below:

Financial Assets		
Cash and cash equivalents	**617,496**	399,267
Trade and Other Receivables	**1,612,897**	193,704
Other	**100,304**	22,746
	2,330,697	615,717
Financial Liabilities		
Trade and other payables	**404,078**	207,155
Corporate Credit Cards	**43,612**	40,901
Income in advance	**1,564,660**	103,829
	2,012,350	351,885

NOTE 16: FINANCIAL RISK MANAGEMENT (continued)

(ii) Interest rate risk

Exposure to interest rate risk arises on financial assets and financial liabilities recognised at reporting date whereby a future change in interest rates will affect future cash flows or the fair value of fixed rate financial instruments.

(iii) Liquidity risk

Liquidity risk arises from the possibility that the company might encounter difficulty in settling its debts or otherwise meeting its obligations related to financial liabilities.
The association manages this risk through the following mechanisms:

- preparing forward looking cash flow analysis in relation to its operational, investing and financing activities;
- maintaining a reputable credit profile;
- managing credit risk related to financial assets;
- investing only in surplus cash with major financial institutions; and
- comparing the maturity profile of financial liabilities with the realisation profile of financial assets.

The tables below reflect an undiscounted contractual maturity analysis for financial liabilities.

NOTE 16: FINANCIAL RISK MANAGEMENT (continued)

	Within 1 Year		1 to 5 Years		Over 5 Years		Total Cash Flow	
	2010	2009	**2010**	2009	**2010**	2009	**2010**	2009
	$	$	**$**	$	**$**	$	**$**	$
Financial liabilities due for payment								
Trade and other payables	**404,078**	207,155	**–**	–	**–**	–	**404,078**	207,155
Corporate credit cards	**43,612**	40,901					**43,612**	40,901
Income in advance	**1,564,660**	103,829	**–**	–	**–**	–	**1,564,660**	103,829
Total expected outflows	**2,012,350**	351,885	**–**	–	**–**	–	**2,012,350**	351,885
Financial assets — cash flows realisable								
Cash and cash equivalents	**617,496**	399,267	**–**	–	**–**	–	**617,496**	399,267
Trade and Other Receivables	**1,612,897**	193,704	**–**	–	**–**	–	**1,612,897**	193,704
Other	**100,304**	22,746	**–**	–	**–**	–	**100,304**	22,746
Total expected inflows	**2,330,697**	615,717					**2,330,697**	615,717
Net (outflow)/ inflow on financial instruments	**318,347**	263,832	**–**	–	**–**	–	**318,347**	263,832

(iv) Credit risk

Exposure to credit risk relating to financial assets arises from the potential non-performance by counter parties of contract obligations that could lead to a financial loss to the company.

Credit risk is managed through the maintenance of procedures (such procedures include the utilisation of systems for the approval, regular monitoring of exposures against such limits and monitoring of the financial stability of significant customers and counter parties), ensuring to the extent possible, that customers and counter parties to transactions are of sound credit worthiness. Such monitoring is used in assessing receivables for impairment.

Risk is also minimised through investing surplus funds in financial institutions that maintain a high credit rating, or in entities that the executive committee has otherwise cleared as being financially sound.

The maximum exposure to credit risk at balance date to recognised financial assets is the carrying amount as disclosed in the statement of financial position and notes to the financial statements. The company does not have any material credit risk exposure to any single debtor or group of debtors.

NOTE 17: COMPANY DETAILS

The registered office of the company is:

National Aboriginal Community Controlled Health Organisation
Level 2, 3 Garema Place
CANBERRA ACT 2601

National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

DIRECTORS' DECLARATION

The directors of the company declare that:

1. The financial statements and notes, as set out on pages 77 to 94 are in accordance with the Corporations Act 2001:
   (a) comply with Accounting Standards and the Corporations Regulations 2001; and
   (b) give a true and fair view of the financial position as at 30 June 2010 and of the performance for the financial year ended on that date of the company.
2. In the directors' opinion there are reasonable grounds to believe that the company will be able to pay its debts as and when they become due and payable.

This declaration is made in accordance with a resolution of the directors.

Director: Justin Mohamed

Director: Lynn McInnes

Dated: 24 August 2010

National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

INDEPENDENT AUDIT REPORT

To the Members of National Aboriginal Community Controlled Health Organisation

Report on the Financial Report

We have audited the accompanying financial report of National Aboriginal Community Controlled Health Organisation (the company), which comprises the balance sheet as at 30 June 2010 and the income statement, statement of recognised income and expenditure and cash flow statement for the year ended on that date, a summary of significant accounting policies and other explanatory notes and the Directors' declaration.

Directors' Responsibility for the Financial Report

The Directors of the company are responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the *Corporations Act 2001*. This responsibility includes establishing and maintaining internal controls relevant to the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

Our responsibility is to express an opinion on the financial report based on our audit. We conducted our audit in accordance with Australian Auditing Standards. These Auditing Standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal controls relevant to the entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal controls. An audit also includes evaluating the appropriateness of

accounting policies used and the reasonableness of accounting estimates made by the directors, as well as evaluating the overall presentation of the financial report.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Independence

In conducting our audit, we have complied with the independence requirements of the *Corporations Act 2001*. We confirm that the independence declaration required by the *Corporations Act 2001* has been provided to the Directors of National Aboriginal Community Controlled Health Organisation.

National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

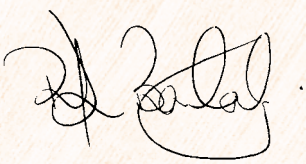
Auditor's Opinion

In our opinion, the financial report of National Aboriginal Community Controlled Health Organisation is in accordance with the Corporations Act 2001, including:

i.giving a true and fair view of the company's financial position as at 30 June 2010 and of their performance for the year ended on that date; and

ii.complying with Australian Accounting Standards (including the Australian Accounting Interpretations) and the Corporations Regulations 2001.

PKF Di Bartolo Diamond and Mihailaros



Ross Di Bartolo
Partner
Canberra

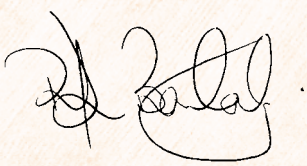
Dated: 24 August 2010

National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

Disclaimer to the Members of National Community Controlled Health Organisation

The additional financial data presented on pages 100–101 is in accordance with the books and records of the company which have been subjected to the auditing procedures applied in our statutory audit of the company for the financial year ended 30 June 2010. It will be appreciated that our statutory audit did not cover all details of the additional financial data. Accordingly, we do not express an opinion on such financial data and we give no warranty of accuracy or reliability in respect of the data provided. Neither the firm nor any member or employee of the firm undertakes responsibility in any way whatsoever to any person (other than National Aboriginal Community Controlled Health Organisation) in respect of such data, including any errors of omissions therein however caused.

PKF Di Bartolo Diamond and Mihailaros
GPO Box 588
CANBERRA ACT 2601



Ross Di Bartolo
Partner
Canberra

National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

ADDITIONAL INFORMATION

Detailed Profit and Loss

For the year ended 30 June 2010

	2010 $	2009 $
INCOME		
Interest	**16,947**	29,678
Grant funding and Subsidies	**4,221,770**	3,284,248
Other income	**55,503**	18,327
TOTAL INCOME	**4,294,220**	3,332,253
LESS EXPENSES		
Audit fees	**13,500**	13,500
Advertising, Media distribution	**8,402**	17,021
AGM and Board Meetings	**124,970**	102,908
Bank charges	**2,247**	3,690
Cleaning	**16,281**	10,509
Computer expenses	**11,384**	15,093
Consultancy fees	**370,852**	88,500
Consumables	**18,643**	14,412
Depreciation	**28,708**	24,916
Donations	**-**	100
Doubtful debts provision	**-**	25,520
Electricity	**8,422**	8,020
Employees' amenities	**17,639**	14,794
Insurance	**12,202**	11,011
Interest paid	**423**	263
Leasing and hire charges	**-**	-

National Aboriginal Community Controlled Health Organisation ABN 89 078 949 710

Detailed Profit and Loss (continued)

For the year ended 30 June 2010

	2010 $	2009 $
Legal costs	**1,356**	-
Loss on disposal of non current assets	**893**	4,298
Meetings, workshops and seminar costs	**282,318**	52,503
Motor vehicle expenses	**7,691**	5,725
Operating expenses	**1,417**	4,002
Postage	**4,958**	5,632
Promotional Merchandise	**14,225**	15,782
Printing and stationery	**40,163**	34,267
Recruitment costs	**-**	-
Rent	**226,700**	124,101
Repairs and maintenance	**7,023**	2,176
Salaries and on costs	**2,022,418**	1,946,078
Security costs	**2,862**	432
Storage fees	**12,237**	8,200
Subscriptions	**14,353**	7,427
Superannuation	**135,513**	132,906
Telephone	**64,728**	60,738
Training and professional development	**2,317**	728
Travelling expenses	**816,979**	648,754
TOTAL EXPENSES	**4,291,824**	3,404,006
OPERATING SURPLUS/(LOSS)	**2,396**	(71,753)

APPENDIX 1 — CONTACTS/ORGANISATIONAL DETAILS

Contacts/Organisational Details

If you would like to know more about NACCHO's activities please contact:

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Australia

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NACCHO State and Territory Affiliates:

NSW AH&MRC

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Surry Hills NSW 2010

PO Box 1565
Strawberry Hills NSW 2012

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www.winnunga.org.au

APPENDIX 2 — ABBREVIATIONS AND ACRONYMS

Abbreviations and Acronyms

ABS	Australian Bureau of Statistics
AC	Aboriginal Corporation or Congress
ACCHRTOs	Aboriginal Community Controlled Health Registered Training Organisations
ACCHSs	Aboriginal Community Controlled Health Services
ACRRM	Australian College of Rural and Remote Medicine
ADNs	Aboriginal Disability Networks
AF	Asthma Foundation
AGM	Annual General Meeting
AHAC	Aboriginal Health Advisory Committee
AHCSA	Aboriginal Health Council of South Australia
AHCWA	Aboriginal Health Council of Western Australia
AHMRC	Aboriginal Health and Medical Research Council of NSW
AHMAC	Australian Health Ministers Advisory Council
AHS	Aboriginal Health Service
AHW	Aboriginal Health Worker
AHWOC	Australian Health Workforce Officials Committee
AIHW	Australian Institute of Health and Welfare
AIDA	Australian Indigenous Doctors Association
AIDS	Acquired Immune Deficiency Syndrome
AIRC	Australian Industrial Relations Commission
AMA	Australian Medical Association
AMSs	Aboriginal Medical Services
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ANCD	Australian National Council on Drugs
APHC	Aboriginal Primary Health Care
APHCRI	Australian Primary Health Care Research Institute
APY	Anangu Pitjantjatjarra Yunkatjatjarra
ASOS	Asthma Spacers Ordering Scheme
ATSIC	Aboriginal and Torres Strait Islander Commission
ATSIHWWG	Aboriginal and Torres Strait islander Health Workforce Working Group

ATSIHRTON	Aboriginal and Torres Strait Islander Health Registered Training Organisation Network ATSIOW Aboriginal Torres Strait Islander Outreach Worker
ATQF	Australian Training Quality Framework
BBV	Blood borne virus
BIG	Business Improvement Group
CCAHP	Collaborative Centre for Aboriginal Health Promotions
CCHS	Community Controlled Health Services
CCSS	Care coordination and supplementary services program
CEO	Chief Executive Officer
COAG	Council of Australian Governments
CRCAH	Cooperative Research Centre for Aboriginal Health
CRIAH	Coalition for Research to Improve Aboriginal Health
CS&HISC	Community Services and Health Industry Skills Council
CSTDA	Commonwealth, State and Territory Disability Funding Agreement
DAAs	Dosage administration aids
DOHA	Department of Health and Ageing
EPC	Enhanced Primary Care
FACSIA	Department of Family and Community Services and Indigenous Affairs
FTE	Full Time Equivalent
GMBH	Good Medicines, Better Health Project
GP	General Practitioner
HA	Hepatitis Australia
H&DAC	Health and Dental Aboriginal Corporation
HB	Health Board
HC	Health Council
HIV	Human Immunodeficiency Virus
HPF	Health Performance Framework
HREOC	Human Rights and Equal Opportunity Commission
HFL	Healthy for Life
HLSW	Healthy Lifestyle Workers
HOMER	Harmonisation of Multi Centre Ethical Review Project
HREC	Human Research Ethics Committees
HS	Health Service
HSTAC	Human Services Training Advisory Council

HWPC	Health Workforce Principle Committee
ICESCR	International Covenant on Economic, Social and Cultural Rights
IOWs	Indigenous Outreach Workers
ISC	Industry Skills Council
IASHC	Indigenous Australian Sexual Health Committee
INIHKD	International Network of Indigenous Health Knowledge Network
KPI	Key Performance Indicators
MA	Medicare Australia
MAAPs	Medication Access and Assistance Packages
MACASHH	Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis
MACBBVS	Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmitted Infections
M&DHAC	Medical and Dental Health Aboriginal Corporation
MBS	Medical Benefits Schedule
MSOAP	Medical Specialist Outreach Assistance Program
MSOAP-ICD	Medical Specialists Outreach Access Program-Indigenous Chronic Disease
MOU	Memorandum of Understanding
NACCHO	National Aboriginal Community Controlled Health Organisation
NAGATSIHID	National Advisory Group for Aboriginal and Torres Strait Islander Health, Information and Data
NAHS	National Aboriginal Health Strategy 1989
NAIHO	National Aboriginal and Islander Health Organisation
NAPSAs	Notional Agreements Preserving State Awards
NATSIHC	National Aboriginal and Torres Strait Islander Health Council
NATSINSAP	National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan
NCHECR	National Centre for HIV Epidemiology and Clinical Research
NCIRS	National Centre for Immunisation Research and Surveillance
NES	National Employment Standards
NHMRC	National Health and Medical Research Council
NIDAC	National Indigenous Drug and Alcohol Committee
NIDN	National Indigenous Disability Network
nKPIs	national Key Performance Indicators
NPS	National Prescribing Service
NSFATSIH	National Strategic Framework for Aboriginal and Torres Strait Islander Health

OATSIH	Office of Aboriginal and Torres Strait Islander Health
OIPC	Office of Indigenous Policy Coordination
OSCAR	OATSIH Support Collection, Analysis and Reporting
PBAC	Pharmaceutical Benefits Advisory Committee
PBS	Pharmaceutical Benefits Scheme
PGA	Pharmacy Guild of Australia
PHCAP	Primary Health Care Access Program
PIP	Practice Incentive Payment
PIRS	Patient Information Recall System
QAIHC	Queensland Aboriginal and Islander Health Council
QUM	Quality Use of Medicine
QUMAX	Quality Use of Medicines Maximised for Aboriginal peoples and Torres Strait Islanders
RACGP	Royal Australian College of General Practitioners
RACP	Royal Australian College of Physicians
RDAA	Rural Doctors Association of Australia
RTO	Registered Training Organisation
RWA	Rural Workforce Agency
SAMSIS	Secure Aboriginal Medical Services Information Systems
SAR	Service Activity Reporting
SBO	State Based Organisations of the GP Divisions
SCARF	Support, Collection, Analysis and Reporting Function of the Healthy for Life Program
SDRF	Service Development Reporting Framework
SEWB	Social and Emotional Well Being
SFA	Single Funding Agreement
STI	Sexually Transmitted Infection
TAC	Tasmanian Aboriginal Centre
TAC	Tobacco Action Workers
UN	United Nations
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
WACRRM	Western Australian Centre for Remote and Rural Medicine
WELL	Workplace English Language and Literacy
WIPO	Workforce Issues Policy Officer
WSF	Aboriginal and Torres Strait Islander Health Workforce Strategic Framework