IAHA

Annual Report

July 2012 — June 2013

2013 IAHA Annual Report

Indigenous Allied Health Australia is the national peak body representing Aboriginal and Torres Strait Islander allied health professionals and students.

Indigenous Allied Health Australia
6b Thesiger Court Deakin West ACT 2600
PO Box 323 Deakin West ACT 2600
Phone: +61 2 6285 1010
Fax: +61 2 6260 5581
www.iaha.com.au
ABN: 42680384985

Acknowledgements

IAHA acknowledges the original artwork by artist Colleen Wallace of Utopia, NT, which is used in the IAHA logo. The original artwork depicts people coming together to meet.

IAHA also acknowledges original artwork by artist Jade-Aaron Williams, a proud descendant of the Wiradjuri and Barkinji peoples of Western NSW.

Indigenous Allied Health Australia receives funding from the Australian Government Department of Health and Ageing.

We pay our respects to the traditional custodians across the lands in which we work, and acknowledge elders past, present and future.

IAHA wishes to advise people of Aboriginal and Torres Strait Islander descent that this document may contain images of persons now deceased.

Contents

“If I can inspire just one other person, I will be happy.”

- Lynelle Fallon, Radiography Student.

Blue Mountains, NSW

Section 1:

About IAHA

IAHA Board of Directors

Faye McMillan - Chairperson

Faye is a Wiradjuri woman from Trangie, Central Western New South Wales. She completed her pharmacy degree at the Charles Sturt University in 2001. She is the first Aboriginal person in Australia to gain a pharmacy degree and to go onto registration as a pharmacist. Faye is currently the Director of the Djirruwang Program, School of Nursing, Midwifery and Indigenous Health at Charles Sturt University, Wagga Campus. She has undertaken further study and completed a Masters in Indigenous Health.

Kylie Stothers - Deputy Chairperson

Kylie is a Jawoyn woman born and raised in Katherine, Northern Territory. After graduating she spent 12 years working throughout the Northern Territory – both Top End and Central, in areas such as child protection, hospital and Aboriginal community controlled health services. She currently lives and work's back in her home town of Katherine, and work as a Lecturer with the Centre for Remote Health in the Katherine Office.

Rebecca Allnutt - Director

Rebecca lives in Alice Springs, Northern Territory. She has a double major in Psychology, as well as a post graduate diploma in Audiology, both from Queensland University. She commenced her own Audiology practice in March 2011 in Alice Springs with three other business partners. She also does community work with the NT Government Hearing Services. In 2008, Rebecca was awarded a Public Service Medal for her services to Indigenous Ear Health.

Kelleigh Ryan - Director

Kelleigh was born in Rockhampton, a descendent of the Kabi Kabi people of Queensland. She graduated from Griffith University with BPsySc (Hons) in 2009. She is currently working as a project officer in research for the Aboriginal and Torres Strait Islander Healing Foundation and as a psychologist in Queensland. Kelleigh is a committee member of the Children by Choice Association in Queensland, which provides training, educational material and counselling around unplanned pregnancies, sexual health and wellbeing.

Keona Wilson - Director

Keona has worked as a speech pathologist at Dharruk Aboriginal Medical Services based at Mt Druitt, Sydney. She currently works for the NSW Health Department – Illawarra Shoalhaven Health District as a clinical leader in speech pathology. Her work includes specialist caseload paediatrics feeding – that is, providing treatment for infants experiencing dysphagia (trouble swallowing). Keona has also worked on a local pilot project called Boori Binji, which was an early intervention initiative for improving language outcomes for pre-school children.

Di Bakon - Director

Di Bakon is originally from NSW, a Kamilaroi woman with origins to the Narrabri area. She is a mature aged student studying third year Occupational Therapy at James Cook University (JCU) in Townsville. Di is currently the chair for the Indigenous Health Students Association at JCU and works hard to support success and retention of Indigenous students through peer support and mentoring students in health degrees. She also supports the Indigenous Health Unit at JCU by doing an Indigenous Health Careers Road show and other Indigenous ambassador activities such as Closing the Gap, Vibe Alive and FOGS.

Thomas Brideson - Director

Tom Brideson is a Kamilaroi man who was born in Gunnedah, NSW. Since 2007 Tom's has occupied the position of State-wide Coordinator of the NSW Aboriginal Mental Health Workforce Program. Tom sits on a range of Committee's at the Local, State and National levels. Tom Chairs the Aboriginal Advisory Committee with the NSW Centre for Rural and Remote Mental Health. Tom is the Chair of management committee of The Mental Health Services Conference (TheMHS), and convened the TheMHS Summer Forum in 2008, Aboriginal and Torres Strait Islander Mental Health. In 2011 Tom was appointed to the first National Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group. In November 2011 Tom was appointed to the NSW Suicide Prevention Ministerial Advisory Committee.

IAHA Board of Directors *continued*

Justin Cain - Director

Justin is a Gamilaroi/Yuin man from Moree and the South Coast of NSW respectively. Justin is a recent graduate of a Bachelor of Science (Exercise Science) degree from the University of Wollongong and is an advocate for students and young people to pursue tertiary education in health disciplines. He is the outgoing Indigenous health portfolio representative for the National Rural Health Students' Network (NRHSN) and was the 2012 recipient of the NRHSN's Janie Dade-Smith award for his contribution to Indigenous health.

Jane Havelka - Director

Jane Havelka is a Wiradjuri woman from Narromine Wongabon currently residing in Wagga Wagga, NSW. Jane is currently the Clinical Coordinator/ Lecturer for the Djirruwang (Mental Health) Program in the School of Nursing, Midwifery & Indigenous Health at Charles Sturt University. She is currently studying her Doctorate of Health Science. In addition she is a qualified Aboriginal and Torres Strait Islander Mental Health First Aid Instructor.

Kelli McIntosh - Director

Resigned 7th January 2013.

IAHA Secretariat - Organisational Chart

Craig Dukes
Chief Executive Officer

Amanda Johnstone
Administration Officer

Donna Murray
Deputy Chief Executive Officer

Anna Leditschke
Senior Policy Officer

Monefa Rusanov
Finance Officer

Larry Brandy
Membership Engagement Officer

Jon Hocking
Communications Officer

Justin Bernau
Legal Counsel
Clayton Utz Lawyers

Kerri Dickman
Accountant
Kerri Dickman Accountants

Kimiah Alberts
Project Officer

Report from the Chairperson

The past year has seen many positive changes for Indigenous Allied Health Australia (IAHA), the national peak body representing Aboriginal and Torres Strait Islander allied health professionals and students. In my second term as chair it is pleasing to see the organisation further develop and evolve into a stronger national voice for Aboriginal and Torres Strait Islander allied health, within the context of improving the health and wellbeing outcomes.

I would like to acknowledge and thank all Board members for their contribution to IAHA during the past year. We held our third annual general meeting on 24 November 2012 in Brisbane, where three new members were elected to the Board of Directors. I would like to thank outgoing Directors for their hard work and commitment for the duration of their term.

Following the AGM, IAHA adopted a new constitution which broadens our membership criteria and strengthens corporate governance structures. This was required in order to develop as a national organisation and transition from an association incorporated under the *Associations Incorporation Act 1981 (Vic)* to become a Company Limited by Guarantee under the *Corporations Act 2001* (Cth).

IAHA has consolidated its strategic direction, with the finalisation of the IAHA Strategic Plan 2012-17 in late 2012 and the IAHA Board of Directors have guided the development of and endorsed several new policy position papers. These provide a solid foundation upon which IAHA can progress initiatives that will positively impact on the health and wellbeing of Aboriginal and Torres Strait islander peoples.

The IAHA Board of Directors values the unique perspectives and needs of our student membership and are committed to building the leadership capacity of our student members. We are delighted that from the 2013 Annual General Meeting there will be a designated position on the Board for a student full member.

Active participation by IAHA on the National Health Leadership Forum, Department of Health and Ageing National Aboriginal and Torres Strait Islander Health Plan Stakeholder Advisory Group and the Close the Gap Steering Committee, as well as a range of health and workforce advisory committees has continued to ensure that Aboriginal and Torres Strait Islander knowledge informs decision-making and policy development around allied health issues.

The Board has undertaken extensive training in governance, financial governance and work health and safety. We have continued to build on our skills and knowledge in order to consolidate our governance capacity and guide the work undertaken by IAHA with confidence.

I would like to acknowledge and thank our primary funding body, the Department of Health and Ageing, which provides the resources to enable IAHA to undertake vital work in Aboriginal and Torres Strait Islander health and the allied health workforce.

Finally, I would like to acknowledge the hard work of the IAHA secretariat, who diligently follow our direction to implement the vision, purpose and strategic direction of IAHA. I commend their ongoing commitment to support our growing membership, strengthen Aboriginal and Torres Strait Islander allied health workforce development and build a more culturally responsive health workforce to improve Aboriginal and Torres Strait Islander health outcomes.

Faye McMillan
IAHA Chairperson

Report from the Chief Executive Officer

It is with pleasure that I am reporting for my fourth year with IAHA. It has been an exciting four years that has seen IAHA grow into highly regarded peak health organisation that is well received in the national health arena. The national profile of the organisation continues to increase and we are acknowledged as the leading authority on Indigenous allied health workforce issues and respected as the peak body representing Aboriginal and Torres Strait Islander allied health professionals and students.

I'd like to acknowledge the support and direction that the Board of Directors have given to the Secretariat as we strive to ensure that the organisation implements strong governance and accountability processes. Good governance is essential to running a successful organisation and the processes now in place will ensure the viability of the organisation well into the future. We have successfully built on our profile over the past twelve months, and delivered on our core priorities set out in the strategic plan, particularly in relation to the support of our student members.

IAHA has maintained its strategic alliances with a number of key organisations within the Aboriginal and Torres Strait Islander and allied health space. We continue to provide strong leadership in relation to a number of Health Workforce Australia (HWA) committees including the Aboriginal and Torres Strait Islander Health Workforce Advisory Committee, Project Advisory Group for the development of the Aboriginal and Torres Strait Islander Health Curriculum Framework Allied Health Stakeholder Consultative Group and Health Profession Standing Advisory Group. This collaborative relationship has been useful as we work towards building and supporting the broader Aboriginal and Torres Strait Islander health workforce.

IAHA continues our close working relationship with the Department of Health and Ageing, the Chief Allied Health Officer and key ministers in relation to Aboriginal and Torres Strait Islander allied health issues. This has been particularly evident in the development of the National Aboriginal and Torres Strait Islander Health Plan in which IAHA took a leading role.

2013-14 is shaping up to be another productive year and I am looking forward to furthering our efforts to strengthen and support the IAHA membership and positively impact on the health and wellbeing of Aboriginal and Torres Strait Islander peoples.

Highlights

- Transitioned from an association incorporated under the *Associations Incorporation Act 1981 (Vic)* to become a Company Limited by Guarantee under the *Corporations Act 2001 (Cth)*
- Increased the number of Full Members
- Hosted our first National Conference in Brisbane
- Allocated significant scholarship funding for members to attend the National Conference and AGM through the National Rural Health Alliance RCHE funding round.
- Nine IAHA Board Meetings held throughout the reporting period, either face to face or via teleconference
- Expanded the Secretariat to include a Communications Officer and Membership Engagement Officer
- Finalised the IAHA Strategic Plan 2012-17
- Developed four policy position papers
- Redeveloped the IAHA Website and functionality
- Hosted our third Annual General Meeting and Members Forum in Brisbane
- Maintained Deductible Gift Recipient status as a charitable health organisation
- Held corporate governance, work health and safety and financial governance training for Directors and Secretariat

Craig Dukes
Chief Executive Officer

History of IAHA

February 2008	The Koori Occupational Therapy Scheme developed a proposal for funding to establish an Indigenous allied health network. The proposal was auspiced by Allied Health Professions Australia.
July 2008	The Australian Government Department of Health and Ageing funded a 12 month project to establish the Indigenous Allied Health Network.
9th June 2009	Nine Aboriginal and Torres Strait Islander allied health professionals attend the first General Meeting of Indigenous Allied Health Australia. During the meeting the purposes and objectives of IAHA and the proposed Rules were adopted. The first Committee of Management was appointed.
12th June 2009	Indigenous Allied Health Australia was incorporated under the *Associations Incorporation Act (1981 Vic)* as a national association.
July 2009	The Australian Government Department of Health and Ageing provided 12 months funding to Indigenous Allied Health Australia Inc.
2nd December 2009	IAHA's CEO appointed.
1st March 2010	IAHA's office was established at 10 Thesiger Court Deakin ACT 2600.
8th July 2010	IAHA Inc held a Launch celebration at the Koorie Heritage Trust in Melbourne.
March 2012	Moved into larger premises as a result of an increase in staff.
November 2012	Held the first IAHA National Conference and 3rd annual general meeting in Brisbane.
November 2012	IAHA Members voted to transfer organisational structure to become a "Company Limited by Guarantee" (CLG) under the *Corporations Act 2001 (Cth) (Corporations Act).*
April 2013	IAHA applied to ASIC to become a "Company Limited by Guarantee" (CLG) under the *Corporations Act 2001 (Cth) (Corporations Act).*

West MacDonnell Ranges, Alice Springs, NT

Section 2:

Objectives

Our Strategic Direction

IAHA Vision

IAHA appreciates all people working in Indigenous health and values the holistic approach to health care and education, in respect of Aboriginal and Torres Strait Islander people, their culture, spirituality, traditional healing, inspiring us to work collegiately in following our vision:

For Indigenous Australians to have access to professionally and culturally competent allied health services delivered by Indigenous allied health professionals who are recognised and acknowledged as an essential part of a holistic approach to Indigenous Health.

IAHA Purpose

In consideration of our constitution and to fulfill the aspirations of our members and needs of Aboriginal and Torres Strait Islander peoples and communities, the purpose of IAHA is:

To advance the health status of Indigenous Australians through IAHA's contribution to the national health agenda, facilitation of improved education opportunities for and representation of Indigenous allied health professionals.

The following objectives and strategies will assist IAHA in meeting our vision and purpose:

Objective 1: To support an engaged IAHA membership

- Increase IAHA membership
- Strengthen and support IAHA membership
- Strengthen IAHA student support
- Facilitate improved professional cultural competence

Objective 2: To provide strong leadership in Indigenous allied health

- Develop and maintain relationships with governments, and other stakeholder organisations
- Strengthen the Indigenous allied health workforce across urban, regional and remote Australia
- Ensure strong and respectful cultural connections
- Provide sound health policy advice

Objective 3: To operate within a sound governance framework

- Ensure sound corporate governance
- Ensure sound operational policies and procedures
- Ensure communication strategies are effective and relevant to member and stakeholder needs
- Maintain accountability and transparency in governance

Objective 4: To achieve and maintain organisational sustainability

- Ensure financial viability
- Facilitate retention of membership and stakeholders
- Maintain a strong advocacy role on behalf of members
- Strengthen and maintain IAHA national profile as Indigenous allied health peak organisation

Objective 1: To support an engaged IAHA membership

The new IAHA constitution endorsed at the 2012 IAHA Annual General Meeting allows for the engagement of a broader range of potential members, particularly associate members (individual and corporate) and Aboriginal and Torres Strait Islander allied health students. It states that there shall be four categories of IAHA membership, as follows:

1. **Full Member - Allied Health Graduate**

   A person is eligible for membership as an Allied Health Graduate Full Member of the Company if they:

   a. are an Aboriginal and/or Torres Strait Islander person;
   b. have graduated from an Allied Health Course with a recognised qualification; and
   c. are accepted by the Board as having commitment to the Objects of the Company.

2. **Full Member - Allied Health Student**

   A person is eligible for membership as an Allied Health Student Full Member of the Company if they:

   a. are an Aboriginal and/or Torres Strait Islander person;
   b. are enrolled in an Allied Health Course (and have not graduated from an Allied Health Course with a recognised qualification); and
   c. are accepted by the Board as having a commitment to the Objects of the Company.

3. **Associate Member - Individual**

   An individual is eligible for membership as an Associate Member of the Company if the individual is accepted by the Board as having a commitment to Objects of the Company.

4. **Associate Member - Corporate**

   An organisation is eligible for membership as an Associate Member of the Company if the corporation is accepted by the Board as having a commitment to the Objects of the Company.

Current Membership Profile

As at 30 June 2013 IAHA had 307 members, comprising 135 full members and 172 associate members.

In May 2013 there was an immediate drop in member numbers following the transition of IAHA from an Association to a Company Limited by Guarantee - overall membership initially decreased by 48.03%, full membership decreased by 42.37% and associate membership decreased by 51.81%. This was an expected drop

as members of the previous association were required to provide written consent to be a member of the new company. However there was a strong surge in membership following the transition.

From July 2012 to June 2013:

- Overall Membership slightly decreased from 324 to 307 members
- Full Membership increased from 104 to 135 members
- Associate Membership decreased from 220 to 172 members

It is positive to note that while associate membership has decreased, full membership has significantly increased over the 2012/13 financial year.

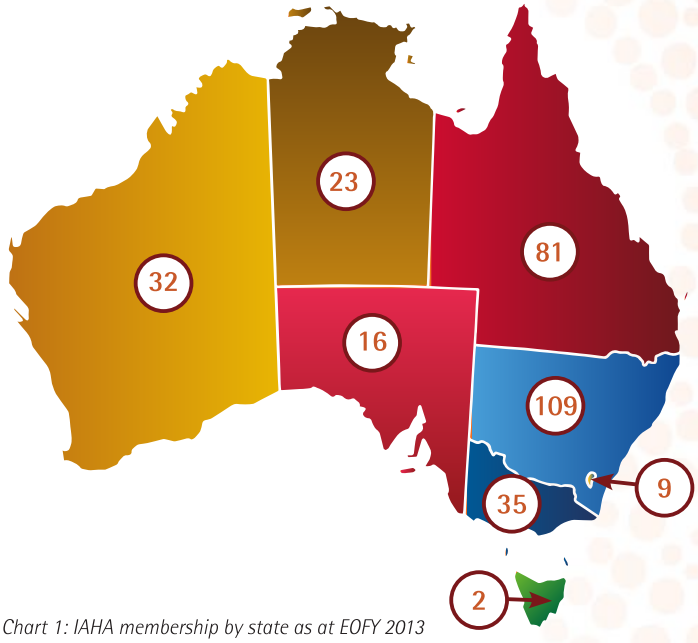


Chart 1: IAHA membership by state as at EOFY 2013

IAHA Membership

Full Members:
ACT: 5
NSW: 63
NT: 5
QLD: 33
SA: 5
TAS: 0
VIC: 7
WA: 17

Associate Members:
ACT: 4
NSW: 46
NT: 18
QLD: 48
SA: 11
TAS: 2
VIC: 28
WA: 15

Full Membership

Of the 135 full members at 30 June 2013, 74 were graduates of an allied health course and 61 were currently studying an allied health course.

The allied health professions most strongly represented in the full membership categories are mental health, social work, occupational therapy, psychology and physiotherapy. Other professions represented include speech pathology, dietetics/nutrition, exercise science/physiology, pharmacy, medical imaging/radiography, audiology and social welfare.

Associate Membership

The allied health professions most strongly represented in the individual associate membership category were occupational therapy, speech pathology, physiotherapy and social work.

Other professions represented within the individual associate membership category include dietetics/nutrition, psychology, exercise physiology, podiatry, optometry, pharmacy, audiology, radiography, primary health care, health science, education, nursing, counselling and paramedicine.
In May 2013 IAHA was pleased to welcome its first corporate associate member, the Central Australian Aboriginal Congress Aboriginal Corporation.

IAHA Member Engagement and Support

IAHA has a strong commitment to support our full and associate membership and strengthen their opportunities through supporting and building personal and professional capacity through development opportunities.

Mentoring Program

The IAHA online mentoring program was launched in November 2012 at the IAHA national conference. There are currently 49 mentors available to members on the IAHA mentoring website at **www.iahamentoring.com.au**. There is great diversity in the skills, knowledge and experience of these mentors, including cultural, interpersonal and profession specific areas of expertise. IAHA student members have been particularly interested in accessing the mentoring program.

The mentoring program involves commitment by both mentor and mentee, and is supported by the IAHA secretariat and an online training program. The training program component will consist of resources and other communication materials to assist in building a strong and trustworthy relationship between the mentor and mentee including the cultural responsiveness components.

IAHA Website & Communication

IAHA launched its new website **www.iaha.com.au** in March 2013. The website has a new look and feel in line with the new IAHA corporate image. Its enhanced functionality has ensured that members are able to access information more easily and effectively.

The website features a members' only area to provide networking and support through forums where members can freely and safely interact.

A new section has been added to the website which features the '*Journeys into Allied Health*' of a number of IAHA members. These inspirational stories provide insight into the diverse paths that can lead to a successful career in allied health. Several of these stories have been featured in publications such as National Indigenous Times and the Health Scoop Magazine.

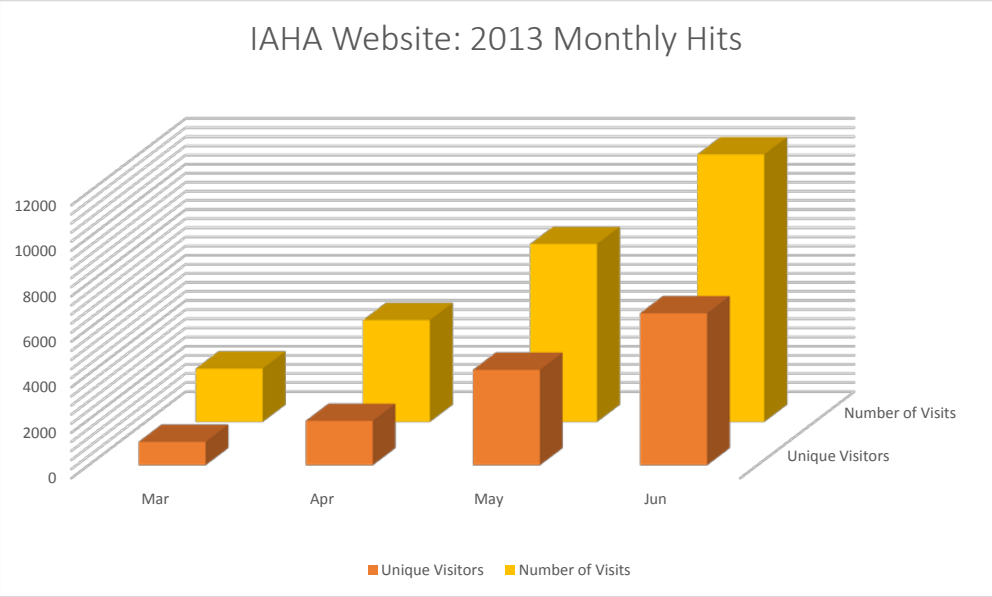


Chart 2: Usage data to 30 June 2013 for iaha.com.au, which was launched in March 2013.

All IAHA position papers and national submissions are also now available for download on the website.

IAHA sends out a bi-monthly eNewsletter to over 1200 recipients. This eNewsletter keeps IAHA members and stakeholders up to date with current events and opportunities available in allied health and the broader Aboriginal and Torres Strait Islander health and wellbeing context.

Social Media

IAHA created a Facebook page in September 2012 in order to promote allied health and the work of IAHA. Between September 2012 and June 2013 over 6300 people have either seen our stories, commented and/or shared IAHA information and 178 people liked the page.

IAHA established a Twitter account in late April 2013. As at June 2013 @IAHA_National had 203 followers.

Professional Development Support

IAHA has established Members Conference Support Guidelines and an application for members to attend conferences and other activities for their professional development. In 2012-13 over 50 IAHA members applied for professional development scholarships to attend the IAHA National Conference and AGM in 2012. Many of those members who were successful in gaining a scholarship could not have attended the three day event without financial assistance, particularly the student members. Funding for this was granted by the Rural Health Continuing Education (RHCE) fund through the National Rural Health Alliance.

A Board Member and employee were supported to attend an international professional development course on Indigenous Governance - Rebuilding Native Nations. Core principals within this course can be transferred into the governance and leadership work of our organisation.

Another two full members submitted a request for support to present papers at an international conference later in 2013. These members are two of only four Australians who were accepted to present.

Student Member Support

In their commitment to supporting allied health students, the IAHA Board proposed changes to the new constitution for IAHA Ltd at the 2012 AGM to have a specific Student Full Membership Category. This was passed by resolution at the AGM and came into effect in April 2013.

In March 2013 a Membership Engagement Officer joined the IAHA secretariat. This has seen a strengthening of support for members, particularly student members which was requested at the 2012 AGM. All Indigenous Support Centres across Australia have been contacted and some strong relationships are being developed.

IAHA has drafted a consultation model and way forward for establishing a student advisory or representative group to assist in meeting their needs and building their leadership and governance capacity. Planning is underway for a Student Leadership Workshop to be held in September 2013 that will aim to build the leadership and governance capacity of student members. This will assist them as they transition into future roles within the allied health workforce and will be particularly useful if they choose to nominate for the new role of IAHA Board Director (Student).

Tax deductible donations to IAHA have contributed to the members conference support initiative which has seen students attend both national and international events, including the HWA Future Health Leaders Conference and the 2nd International Indigenous Voices in Social Work conference in Winnipeg, Canada.

Marketing and Promotion

With a full-time Communications Officer this year IAHA has been able to increase its focus on promotional materials and ensure a strong, eye-catching representation at events. IAHA has developed a comprehensive suite of marketing materials, including brochures, posters, flyers, banners and apparel targeted toward specific audiences that aim to:

- Promote careers in allied health to Aboriginal and Torres Strait Islander people;
- Promote the role of IAHA as a national allied health peak body and benefits of membership; and
- Facilitate an understanding and appreciation of the role that allied health professionals play in the delivery of care to Aboriginal and Torres Strait Islander people.

Key messages include:

'Think Outside the Square'

'Make a difference, be an allied health professional'

IAHA promotional items

IAHA is in the process of developing an Allied Health Careers Booklet which focuses on encouraging Aboriginal and Torres Strait Islander people to investigate a career in allied health, including the personal attributes required and support structures available. It will feature Aboriginal and Torres Strait Islander allied health professionals and students sharing their experiences. It is anticipated that this booklet will be launched in 2014.

Events

IAHA 2012 National Conference

The inaugural IAHA National Conference - An Inter-professional Approach to Indigenous Health was held in Brisbane on 22-23 November 2012. Over 200 delegates from all over Australia attended the conference, with 100% of those surveyed being satisfied or very satisfied with their overall experience.

The conference brought together an impressive line-up of keynote speakers such as Dr Tom Calma who gave the opening keynote address and the Aboriginal and Torres Strait Islander Social Justice Commissioner Mr Mick Gooda who provided the closing statement on lateral violence and the importance of human rights recognition in health. The international guest was Ms Riripeti Haretuka who provided an informative keynote on the health and wellbeing and community engagement strategies of Maori peoples. They were joined by Congress of Australia's First Peoples co-chair Jodie Broun and a number of Aboriginal and Torres Strait Islander allied health professionals, researchers, educators and students from all over Australia.

The conference was designed to make delegates think about how allied health professionals and stakeholders can contribute towards a sustainable approach to improving the health of Aboriginal and Torres Strait Islander people, working in an inter-professional and holistic environment. It featured stories from allied health professionals working on the ground and the overall feel of the conference was one of unity and collaboration.

Both the Prime Minister the Hon. Julia Gillard and the Minister for Indigenous Health the Hon. Warren Snowdon provided video messages of support for the work of IAHA and allied health professionals. This was widely seen as a demonstration of commitment to building and supporting the Aboriginal and Torres Strait Islander allied health workforce.

'Well done. Your hard work has been a gift to all delegates and exhibitors. May this be the first of many.'
– Delegate from Education Sector

'A very well organised conference. Great speakers and great networking. I present and attend many conferences each year, and this is up there with the best of them.'
– Allied health professional, Nutrition/Dietetics

'Overall I found the conference to be thought provoking, emotive and motivational.'
– Social Worker

Chart 3: Overall satisfaction data compiled from attendees of 2012 IAHA National Conference

2012 Annual General Meeting (AGM) and Members Forum

IAHA held a Members Forum, followed by its 3rd AGM on Saturday 24 November 2012 in Brisbane. The Members' Forum, facilitated by the IAHA Board, allowed vigorous discussion around a number of issues relevant to the future of IAHA. This included definition of Indigenous allied health, company and constitutional changes and member support initiatives.

The 2011-12 financial reports and audit report were discussed to clarify any issues prior to the AGM. Clayton Utz Lawyers then joined the Board to discuss the proposed move from an association to a Company Limited by Guarantee and the new constitution.

At the AGM, members agreed that IAHA Inc. would apply to transfer its incorporation under the Victorian legislation to become a Company Limited by Guarantee under the *Corporations Act 2001 (Cth)*, to be registered in the Australian Capital Territory.

Members subsequently agreed that the Rules of the Association be repealed and replaced in its entirety upon its registration as a Company Limited by Guarantee under the Corporations Act 2001 with the constitution as tabled at the annual general meeting.

Three new board members were successfully inducted, joining the existing six board members. The first meeting of the Board took place directly after the AGM and Ms Faye McMillan was re-elected as Chair and Ms Kylie Stothers Deputy Chair.

National Close the Gap Day

IAHA joined over 900 other events and cohosted a morning tea for National Close the Gap Day on Thursday 21st March 2013 with a partner organisation, the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA). The event was held at the ACT Aboriginal and Torres Strait Islander Cultural Centre and highlighted the great work of Australia's largest ever Aboriginal and Torres Strait Islander health campaign, of which IAHA is a key stakeholder and partner. Over 30 people attended to watch the Close the Gap DVD 'Investing in a Healthy Future' and see the Ngambri dancers perform while enjoying the surrounds and Indigenous art and crafts from around the country in the gallery.

Other Events

Many IAHA members contribute significantly to the promotion and marketing of allied health, attending community and career promotion events across the country. IAHA thanks those members who volunteer their valuable time, knowledge, expertise and experiences to engage Aboriginal and Torres Strait Islander peoples around the many opportunities available in allied health.

Objective 2: To provide strong leadership in Indigenous allied health

Key Partnerships and Representation

IAHA continues to work in partnership with other Indigenous peak health organisations who are committed to building and strengthening the Aboriginal and Torres Strait Islander health workforce. This includes the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA), Australian Indigenous Doctors Association (AIDA), National Aboriginal Community Controlled Health Organisation (NACCHO), Congress of Australia's First Peoples and Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN).

IAHA was an active partner with AIDA in supporting their health careers workshop Murra Mullangari held in April 2013 and was a committed member of the project advisory committee. IAHA members in specific allied health careers attended and presented their journey to students attending the workshop which was a great success. We look forward in working with AIDA in future health career workshops.

IAHA is working closely with Universities, professional associations, health organisations and governments to promote IAHA and provide leadership on relevant allied health areas such as racism in health and the importance of allied health as well as advocating strongly for cultural responsiveness in education, workplace and individual health professionals.

IAHA has presented at a number of conferences including 2012 National SARRAH Conference (the 10th National Rural and Remote Allied Health Conference), PRIDoC Conference and the 12th National Rural Health Conference - Strong Commitment Bright Future.

IAHA continues to establish new and build on existing relationships with key partners and stakeholders to ensure that Aboriginal and Torres Strait Islander views are well represented within national conversations, ensuring allied health is kept at the forefront of discussions. IAHA advocates strongly for better access, affordability, availability and appropriateness for Aboriginal and Torres Strait Islander people to allied health services across the community, government and private sector.

As a national advocate for Aboriginal and Torres Strait Islander allied health professionals and students, IAHA is represented on the following committees, groups and alliances:

- Aboriginal & Torres Strait Islander Health Workforce Working Group
- Close the Gap Campaign Steering Committee
- National Congress of Australia's First Peoples (member and delegate)
- National Health Leadership Forum
- National Aboriginal & Torres Strait Islander Health Plan Stakeholder Advisory Group

- Council of Remote Area Nurses of Australia Plus – Aboriginal and Torres Strait Islander Health Advisory Committee
- Health Workforce Australia (HWA) Aboriginal & Torres Strait Islander Health Workforce Advisory Committee
- HWA Project Advisory Group for the development of the Aboriginal and Torres Strait Islander Health Curriculum Framework
- HWA Standing Advisory Committee For Health Professionals
- HWA Stakeholder Consultation Group for Allied Health
- HWA Conference Committee
- Nursing and Allied Health Rural Locum Scheme Steering Committee
- Puggy Hunter Memorial Scholarship Selection Scheme Committee, Royal College of Nursing Australia
- Leaders In Indigenous Medical Education
- Murra Mullangari Health Program, AIDA
- Program of Experience in the Pallative Approach
- National Primary Health Care Partnership
- Enabling Clinical Support Skills QLD Project Steering Committee
- Nursing & Allied Health Scholarship Support Scheme
- National Rural Health Alliance
- Social Determinants of Health Alliance
- National Allied Health Forum

Close the Gap (CTG) National Steering Committee

IAHA is a member of the Close the Gap Campaign Steering Committee which consists of 29 of Australia's peak Aboriginal and Torres Strait Islander and non-Indigenous health bodies, health professional bodies and human rights organisations who are committed to raising the health and life expectancy of Aboriginal and Torres Strait Islander peoples to that of the non-Indigenous population within a generation: to close the gap by 2030. It aims to do this through the implementation of a human rights based approach set out in the Aboriginal and Torres Strait Islander Social Justice Commissioner's Social Justice Report 2005 and the Close the Gap Statement of Intent.

The Australian Government currently provides an annual report to Parliament on progress towards closing the gap between Aboriginal and Torres Strait Islander and non-Indigenous Australians. Each year the Campaign Steering Committee provides a complementary 'shadow' report representing its assessment of the Australian Government's progress against its commitments to achieving Aboriginal and Torres Strait Islander health equality. IAHA contributed to the development of the fourth shadow report, released in early 2013.

The Campaign Steering Committee is led by its Aboriginal and Torres Strait Islander member organisations, including IAHA. This leadership group was the precursor for the National Health Leadership Forum (NHLF) established in August 2011 from organisational members of Chamber 1 of the National Congress of Australia's First Peoples (Congress).

National Health Leadership Forum (NHLF)

IAHA is an active member of the NHLF, which has established itself as the national representative committee for Aboriginal and Torres Strait Islander peak bodies who provide policy advice on health. As a member of the NHLF, IAHA contributed to the development of various national policy documents, ensuring that allied health issues and perspectives were included.

A key NHLF initiative to which IAHA contributed during 2012-13 was the development of the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP). The NHLF hosted a number of thematic round tables across the country around specific health issues of concern including drug and alcohol, early childhood, health systems, cultural models and traditional healing and mental health. In addition to participating in the national consultation workshops, IAHA took the lead on the mental health roundtable held in Perth and the early childhood roundtable held in Melbourne.

IAHA also made an individual submission to the Aboriginal and Torres Strait Islander Health Plan containing 17 recommendations and their rationale. It was solution focussed and placed particular emphasis on allied health services and workforce development within the context of improving Aboriginal and Torres Strait Islander health and wellbeing. The final plan and its companion document will be released by the Minister for Indigenous Health the Hon. Warren Snowdon in July 2013.

Allied Health Defined

The definitions of 'allied health', 'Indigenous allied health' and 'allied health professional' vary between jurisdictions, sectors and professions. Following widespread consultation and research, IAHA has subsequently developed its own definition of allied health within the context of improving the health and wellbeing of Aboriginal and Torres Strait Islander people. The following definitions were endorsed by the IAHA Board during 2012-13:

IAHA defines allied health as 'a collective term used to refer to a variety of healthcare disciplines that contribute to a person's physical, sensory, psychological, cognitive, social, emotional and cultural wellbeing, excluding medicine, nursing and Aboriginal and Torres Strait Islander health worker/practitioner roles. Allied health functions include but are not limited to, services related to the identification, evaluation, management and prevention of disease and disorders; dietary and nutritional services; and rehabilitation services.'

An allied health professional is considered by IAHA to be a health professional who;

1. Has undertaken a tertiary qualification at Bachelor Degree (AQF Level 7) or higher in an allied health course;
2. Has attained the necessary knowledge, attributes, attitudes and skills required to be an autonomous practitioner and practices in an evidence based paradigm using a recognised body of skills and knowledge to contribute to the physical, sensory, psychological, cognitive, social, emotional and cultural wellbeing of people so that each individual is able to achieve their full potential as a human being; and
3. Does not practice as a doctor, nurse or Aboriginal and Torres Strait Islander Health Worker/ Practitioner.

IAHA embraces a holistic and inclusive approach towards meeting the complex healthcare needs of Aboriginal and Torres Strait Islander people. IAHA is inclusive of a broad scope of allied health professions as we determine the meaning of allied health from an Aboriginal and Torres Strait Islander perspective.

In doing this, we recognise and value the uniqueness of the diverse allied health professions impacting on the delivery of health services to Aboriginal and Torres Strait Islander people, their families and their communities.

Position Papers

2012-13 has seen the finalisation of four key position papers that form the basis of our policy platform. The purpose of these policy initiatives is to highlight key understandings that underpin core IAHA activities. The IAHA Board of Directors have confidence that facilitating common understandings between IAHA and its stakeholders and partners will eventually lead to health system change that can positively impact on the health and wellbeing of Aboriginal and Torres Strait Islander peoples. Here is a snapshot of these policy statements which are available on the IAHA website.

1. The Importance of Allied Health

IAHA acknowledges and respects the critical role that allied health professionals play in Australia's efforts to reform the health system and improve health outcomes for all Australians, particularly Aboriginal and Torres Strait Islander people.

Allied health professionals are an essential element in a responsive and equitable health system that is able to accommodate the widely varying needs of Aboriginal and Torres Strait Islander people, many with chronic and complex conditions.

IAHA asserts that it will be the crucial role played by allied health professionals that will determine the future of the Australian health system and thus positively impact on the health and wellbeing of Aboriginal and Torres Strait Islander people.

2. Racism in Health

IAHA stands against all forms of racism and racial discrimination. IAHA members often play an integral role in addressing racism and improving health outcomes for Aboriginal and Torres Strait Islander people. However the responsibility for eliminating racism from our healthcare system does not just rest with individuals; strong commitment from and collaboration between individuals, organisations and communities is required.

Health is a fundamental human right and every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. Racism and subsequent racial discrimination can impede the achievement of this right for Aboriginal and Torres Strait Islander people, who deserve culturally responsive health service delivery.

IAHA asserts that it will only be through working together that the necessary trust between mainstream organisations and institutions and Aboriginal and Torres Strait Islander people can be established that will lead to an equitable and respectful health system where the dignity of all human beings is celebrated and defended.

3. Access to Allied Health

IAHA believes the gap in life expectancy between Aboriginal and Torres Strait Islander people and other Australians will not be closed until Aboriginal and Torres Strait Islander people have the access they need to high quality allied health services.

Access is more than just physical or geographical access, also including cultural, economic and social factors which all impact on whether Aboriginal peoples and Torres Strait Islander people use allied health services.

IAHA asserts that in order for Aboriginal and Torres Strait Islander people to have equitable access to allied health services, we must work collaboratively to ensure that the services are available, affordable, acceptable and appropriate.

4. Culturally Responsive Health Care

IAHA asserts that a culturally responsive health workforce is imperative in order to ensure Aboriginal and Torres Strait Islander people receive the healthcare required to significantly improve health and wellbeing outcomes.

Culturally responsive care can be defined as an extension of patient centered care that includes paying particular attention to social and cultural factors in managing therapeutic encounters with patients from different cultural and social backgrounds. IAHA views it as a cyclical and ongoing process, requiring health professionals to continuously self-reflect and proactively respond to the person, family or community with whom they interact.

There are multiple layers of responsibility to ensure that Aboriginal and Torres Strait Islander people receive culturally responsive healthcare.

IAHA asserts that all health professionals need to be both clinically competent and culturally responsive to positively affect the health and wellbeing of Aboriginal and Torres Strait Islander people.

Developing a Culturally Responsive Allied Health Workforce

IAHA and partner organisations successfully argued for the development of a culturally inclusive, interdisciplinary Aboriginal and Torres Strait Islander Health Curriculum Framework to be integrated into tertiary entry level health profession training and Health Workforce Australia (HWA) is funding the development of this framework.

However, in order for any Aboriginal and Torres Strait Islander curricula framework to be implemented within health profession training, it must be supported by and embedded within health profession course accreditation. IAHA believes education providers need to be held accountable for the cultural capability of its health graduates.

Examination of Accreditation Standards for registered professions shows that there are varying degrees of importance placed on Aboriginal and Torres Strait Islander health. Medicine and Nursing Accreditation Standards currently lead the way in setting high standards for education providers in the development and implementation of Aboriginal and Torres Strait Islander curricula and working collaboratively with Aboriginal and Torres Strait Islander communities. IAHA is keen to see allied health professions' Accreditation Standards meet or exceed these standards.

IAHA asserts that all Accreditation Standards for both registered and self-regulated professions would be enhanced by being more explicit across all sections around Aboriginal and Torres Strait Islander health, overtly addressing the processes, structures and curriculum requirements needed in order to produce graduates able to work with and deliver culturally responsive care to Aboriginal and Torres Strait Islander people.

As a first step, IAHA worked with its Aboriginal and Torres Strait Islander occupational therapy full members to develop a submission to the Review of the Accreditation Standards for the Occupational Therapy profession. The IAHA submission provided a number of recommendations to assist the OT Council to develop Accreditation Standards that will have a positive impact on the health and wellbeing of Aboriginal and Torres Strait Islander peoples. The full submission is available on the IAHA website and IAHA is positive about the outcome of this input.

National Health Workforce Development

IAHA has a strong working relationship with Health Workforce Australia (HWA), a Commonwealth statutory authority that delivers a national, coordinated approach to health workforce reform. HWA was established to address the challenges of providing a skilled, flexible and innovative health workforce that meets the needs of the Australian community. IAHA participates on several HWA committees including their Aboriginal & Torres Strait Islander Health Workforce Advisory Committee, Project Advisory Group for the development of the Aboriginal and Torres Strait Islander Health Curriculum Framework, Standing Advisory Committee for Health Professionals and the Stakeholder Consultative Group for Allied Health.

In early 2013, IAHA provided a submission to the development of the Health Workforce Australia (HWA) Strategic Plan 2013 – 2016. IAHA proposed that the plan should build, support and extend the essential role that allied health professionals play in the delivery of holistic comprehensive healthcare to Aboriginal and Torres Strait Islander people and other Australians. It also suggested the plan should explicitly articulate how HWA contributes to improving the health and wellbeing of Aboriginal and Torres Strait Islander peoples within its goals, objectives and 'how we work'.

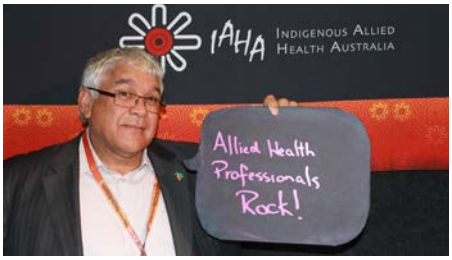
The submission also highlighted that the plan should facilitate sustainable interdisciplinary workforce responses to the health and wellbeing needs of Aboriginal and Torres Strait Islander people and people living in rural and remote locations and other areas of health workforce shortage. It also required that the plan acknowledge the need for and facilitate increased participation of Aboriginal and Torres Strait Islander people in the health workforce, across all disciplines and sectors in addition to increasing cultural responsiveness of the current and future health workforce to meet the needs of Aboriginal and Torres Strait Islander peoples.

It was positive to note that Aboriginal and Torres Strait Islander communities and their representative bodies are specifically named as partners of HWA and that two of the nine strategies documented under the strategic objectives pertain directly to health workforce development within an Aboriginal and Torres Strait Islander context.

Future Allied Health Workforce

IAHA continues to promote careers in allied health to Aboriginal and Torres Strait Islander people across Australia. A particularly successful method of engagement is attending Indigenous specific careers expos across the country. During 2012-13 IAHA was represented at 11 career expos across Australia, delivering our key messages to over 3,000 Aboriginal and Torres Strait Islander people.

In addition to the expos, IAHA members have participated in numerous community events, workshops, meetings at Indigenous Support Centres and university lectures.



IAHA acknowledges and appreciates the multiple pathways available for Aboriginal and Torres Strait Islander people to enter the allied health workforce. Building a strong foundation by strengthening pathways within the Vocational Education and Training (VET) sector is essential to opening up careers in allied health to more people.

Effective recruitment and retention strategies and strong support mechanisms are crucial if we want to increase the number of Aboriginal and Torres Strait Islander people studying allied health courses, in both VET and tertiary settings. Establishing strong partnerships with the health education sector continues to be a core priority for IAHA.

Objective 3: To operate within a sound governance framework.

Corporate Governance

The new IAHA Board of Directors met directly following the AGM held in November 2012 with the Chairperson, Ms Faye McMillan re-elected as the Chair for another term. IAHA had four new Directors join the Board from Exercise Science, Social Welfare, Mental Health and in February 2013 after the resignation of Kelli McIntosh another new Director was elected in Occupational Therapy. As at June 2013 the Board comprised:

- Chair – Pharmacy Representative
- Deputy Chair – Social Work Representative
- Treasurer – Audiology Representative
- Director – Speech Pathology Representative
- Director – Psychology Representative
- Director – Exercise Science Representative
- Director – Social Welfare Representative
- Director – Mental Health Representative
- Director – Occupational Therapy Representative

The Members passed the resolutions to change to a Company Limited by Guarantee, endorsed the new constitution and to broaden the membership categories to include Student Full membership. These changes took effect in April 2013, officially changing the organisation name to Indigenous Allied Health Australia (IAHA) Ltd. The role of Company Secretary is currently held by the CEO, as endorsed by the Board in May 2013.

The IAHA Board held nine Board Meetings in 2012-13 including four face to face meetings and five via teleconference to discuss the strategic direction of IAHA and its core business.

The Board undertook comprehensive governance and financial training with Kerri Dickman Accountants, WorkSafe ACT and Clayton Utz Lawyers, with a particular focus on the legislative requirements for a Company Limited by Guarantee and the role of Board Directors within the new company structure.

The Board also met with a number of key stakeholders, including the Australian Medicare Local Alliance and the Chief Allied Health Officer David Butt. The Board have also entered into discussions with the Australian Council of Pro-Vice-Chancellors and Deans of Health Sciences who have been invited to the August 2013 Board Meeting to discuss a potential collaboration agreement.

The IAHA Board established a new Finance, Audit and Risk Committee to undertake and provide guidance on the finances, risk management, and internal and external audit processes. This new committee met for the first time in May 2013 and has representation from three Board Directors and an external audit and risk expert.

IAHA continues to undertake operational policy development and review to ensure they are relevant and up to date for operational and governance use. The IAHA Governance Charter is a living document that is updated regularly to reflect governance priorities and changes required as part of the transition to a Company Limited by Guarantee.

IAHA has also drafted By Laws for the Nomination and Election of IAHA Directors that outline the new nomination and election process for the first Company Director elections to be held at the first Annual General Meeting of IAHA Ltd in Adelaide 28 November 2013. The AGM and elections will be held in line with the new IAHA constitution, legislation and membership categories.

IAHA continues to uphold the operational and governance policies and procedures set by the Board of Directors and the Secretariat.

The Secretariat ensures that all work performed on behalf of the Board and members is directly related to the current Strategic Plan and the vision of IAHA. Staff members are strongly encouraged to undertake professional development activities or courses that will build their capacity as an individual and within the team. Two staff members are currently undertaking studies in relevant areas.

Accountability and Transparency in Governance

IAHA continues to maintain financial accountability through comprehensive financial reports to the Board at each meeting. The IAHA accountant attends each face to face board meeting to complement financial governance training at the first Board meeting to strengthen their capacity to manage the financial business of IAHA.

As stated previously, the Board endorsed a Finance, Audit and Risk Committee with membership from the Board and an external expert in one or more of the areas. A Finance, Audit and Risk Committee Charter was developed and endorsed by the Board and the first meeting was held in May 2013 in Canberra. This committee reports to the Board at each meeting on the progress and issues that may arise in relation to their scope.

IAHA has clear and concise travel and financial management policies in meeting our reporting requirements and financial targets each quarter.

The IAHA website has been developed to host a member's only section which has specific access for Directors to access governance documents, statements and Board papers. The member's forum at the AGM also provides the opportunity for member feedback and comments about papers and governance documents. IAHA also provides scholarships for members to attend the AGM to enable active member participation in decision making processes.

IAHA ensures all national submissions and policy papers are available on its website for download by members and stakeholders.

Targeted and transparent communication to members occurs via email and eNewsletters to inform and engage members on important issues.

IAHA delivers quarterly reports to its funding body, the Department of Health and Ageing, which detail activities and initiatives against the current strategic plan and funding agreement performance indicators.

Objective 4: To achieve and maintain organisational sustainability.

IAHA has been successful in gaining a 2 year funding agreement with the Department of Health and Ageing to the end of the 2014-15 financial year. IAHA is pleased that it can now commence longer term planning and to develop sustainable activities to support members, initiatives and workforce strategies. The future funding arrangements will have a huge impact on the operations and governance of IAHA and allow IAHA to take on significant longer term projects with partners, particularly professional associations.

IAHA continues to seek additional funding from a variety of sources to build the ongoing sustainability of the organisation. Such additional funding would enhance existing member support mechanisms. It would also strengthen policy development and allow for greater research into the importance of allied health and its impact on the health and wellbeing of Aboriginal and Torres Strait Islander peoples.

The new IAHA website has a dedicated page to our Deductible Gift Recipient (DGR) status for interested parties to make a donation and/or promote the opportunity to our key stakeholders. All donations are placed into a fund to support IAHA members.

At the AGM forum members shared their priorities for 2013 and IAHA has followed these up with a range of activities from policy statements to advocating for student scholarships and looking at more interactive ways to communicate and engage our members through new member engagement guidelines. We have completed surveys with full members so that targeted support can be provided.

IAHA is developing a draft position statement on human rights and hosted an intern from Australian National University (ANU) for three months supporting a paper on the human rights approach to health and the impact allied health professionals can have in a sustainable approach to improving Aboriginal and Torres Strait Islander health.

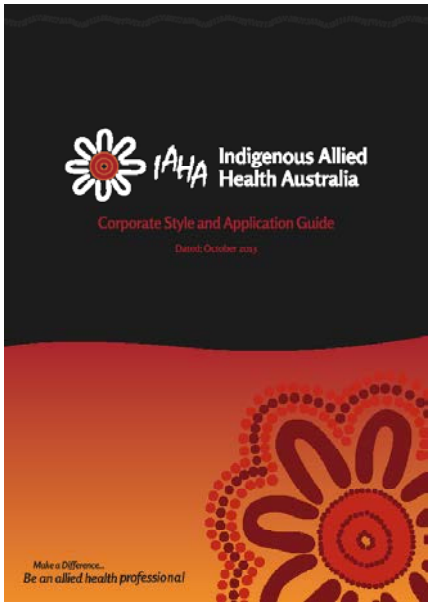
Over the reporting period several IAHA members and students have been actively engaged in representing IAHA at a range of events and expos which strengthens IAHAs membership in promoting their achievements and chosen professions.

IAHA National Profile

All activities outlined within this report have contributed to solidifying IAHA as the national Aboriginal and Torres Strait Islander peak allied health organisation. IAHA provides direction, advice and information at a national level on cultural responsiveness and working with Aboriginal and Torres Strait Islander people, families and communities. This is due to the work of the Board, Members and Secretariat in highlighting the unique perspectives of Aboriginal and Torres Strait Islander allied health professionals and students.

IAHA has developed a corporate style guide to assist in the proper and consistent use of the IAHA logo and branding. Ensuring the consistent representation of IAHA as a brand is an integral part of building awareness amongst potential stakeholders, growing our membership and increasing our national profile. The corporate style guide provides clear guidelines for usage of the brand in all kinds of print and web publications, as well as promotional materials.

As set out above in the various sections in the report IAHA also continues to work closely with professional associations across key professions and will continue to develop new relationships and partnerships with key stakeholders to meet our core priorities set out in the Strategic Plan 2012-17.



“IAHA opens up my support networks to include many other strong Indigenous allied health professionals.”

- Leda Barnett, Psychologist

Magnetic Island off Townsville, QLD

Section 3:

Financial Statements

Indigenous Allied Health Australia
ABN 42 680 384 985

Financial Statements
For the Year Ended 30 June 2013

Board Members' Report

Your board members submit the financial report of the Association for the financial year ended 30 June 2013.

1. General information

Directors

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

Names	Position	Appointed/Resigned
Faye McMillan	Chairperson	Appointed 17/11/2011
Kylie Stothers	Deputy Chairperson	Appointed 17/11/2011
Rebecca Allnutt	Treasurer	Appointed 17/11/2011
Kelleigh Ryan	Director	Appointed 17/11/2011
Keona Wilson	Director	Appointed 17/11/2011
Karla Canuto	Director	Resigned 04/10/2012
Kelli McIntosh	Director	Resigned 07/01/2013
Noell Burgess	Director	Resigned 16/07/2012
Todd Heard	Director	App 22/07/12 Res 24/11/12
Thomas Brideson	Director	Appointed 24/11/2012
Jane Havelka	Director	Appointed 24/11/2012
Justin Cain	Director	Appointed 24/11/2012
Diane Bakon	Director	Appointed 26/02/2013

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

Principal Activities

The principal activities of the association during the financial year were:

- To contribute to improved knowledge and competencies of allied health practitioners working with Aboriginal and Torres Strait Islander peoples and their communities;
- To contribute to improved allied health services for Indigenous people and communities;
- Provide effective support to Aboriginal and Torres Strait Islander members of IAHA

Significant Changes

No significant change in the nature of these activities occurred during the year.

2. Operating Results and Review of Operations for the Year

The profit/(loss) of the Association for the financial year amounted to $(18,882)/(2012: Profit $35,855))
Signed in accordance with a resolution of the Members of the Board:

Director:

Faye McMillan

Director:

Keona Wilson

Dated 16 August 2013

Statement of Profit or Loss and Other Comprehensive Income

For the year ended 30 June 2013

	$ 2013	$ 2012
Income	**1,531,725**	873,807
Marketing expenses	**(101,900)**	(54,264)
Occupancy costs	**(63,500)**	(32,285)
Administrative expenses	**(125,244)**	(98,610)
Employee expenses	**(740,807)**	(512,252)
Finance costs	**(824)**	(1,003)
Board expenses	**(71,315)**	(51,290)
Members meeting expenses	**(36,298)**	(12,124)
Conference expenses	**(29,967)**	(11,376)
Representation expenses	**(62,940)**	(33,947)
Staff meeting expenses	**(35,545)**	(21,951)
Depreciation expense	**(13,399)**	(8,850)
Conference	**(268,868)**	-
Profit before income tax	**(18,882)**	35,855
Income tax expense	**-**	-
Profit for the period	**(18,882)**	35,855
Other comprehensive income:	**-**	-
Total comprehensive income for the period	**(18,882)**	35,855

Statement of Financial Position

For the year ended 30 June 2013

	Note	$ 2013	$ 2012
ASSETS			
CURRENT ASSETS			
Cash and cash equivalents	4	**228,626**	163,448
Trade and other receivables	5	**-**	3,774
Other assets	7	**38,384**	33,133
TOTAL CURRENT ASSETS		**267,010**	200,355
NON CURRENT ASSETS			
Property, plant and equipment	6	**58,368**	28,193
TOTAL NON CURRENT ASSETS		**58,368**	28,193
TOTAL ASSETS		**325,378**	228,548
LIABILITIES			
CURRENT LIABILITIES			
Trade payables	8	**42,912**	27,530
Short term provisions	9	**44,115**	25,902
Other financial liabilities	10	**236,182**	154,065
TOTAL CURRENT LIABILITIES		**323,209**	207,497
NON CURRENT LIABILITIES			
TOTAL LIABILITIES		**323,209**	207,497
NET ASSETS		**2,169**	21,051
EQUITY			
Retained Earning/profit		**2,169**	21,051
TOTAL EQUITY		**2,169**	21,051

Statement for Changes in Equity

For the year ended 30 June 2013

2013	$ Retained Earnings	$ Total
Balance at 1 July 2012	**21,051**	**21,051**
Profit attributable to members of the entity	(18,882)	(18,882)
Sub-total	**(18,882)**	**(18,882)**
Balance at 30 June 2013	2,169	2,169

2012	$ Retained Earnings	$ Total
Balance at 1 July 2011	**(14,804)**	**(14,804)**
Profit attributable to members of the entity	35,855	35,855
Sub-total	**35,855**	**35,855**
Balance at 30 June 2012	21,051	21,051

Statement of Cash Flows

For the year ended 30 June 2013

	Note	$ 2013	$ 2012
CASH FROM OPERATING ACTIVITIES:			
Receipts from customers		1,770,584	835,483
Payments to suppliers and employees		(1,671,688)	(943,574)
Interest received		10,680	7,816
Interest paid		(824)	(1,003)
Net cash provided by (used in) operating activities	16	108,752	(101,278)
CASH FLOWS FROM INVESTING ACTIVITIES:			
Purchase of property, plant and equipment		(43,574)	(7,418)
Net cash used by investing activities		(43,574)	(7,418)
CASH FLOWS FROM FINANCING ACTIVITIES:			
Net cash increase (decreases) in cash and cash equivalents		65,178	(108,696)
Cash and cash equivalents at beginning of year		163,448	272,144
Cash and cash equivalents at end of financial year	4	228,626	163,448

Notes to the Financial Statements

For the year ended 30 June 2013

The financial statements cover Indigenous Allied Health Australia Incorporated as an individual entity. Indigenous Allied Health Australia Incorporated is a not for profit association incorporated in Victoria under the Association Incorporation Act 1981.

1 Change in Operational Structure

On 15 May 2013 Indigenous Allied Health Ltd was registered as a Company Limited by Guarantee. As of 1 July 2013 Indigenous Allied Health Incorporated will cease to trade and Indigenous Allied Health Ltd will take over all operations of the associaiton. It has also been agreed that all programs, assets, liabilities and staff obligations be transfered on this date.

2 Summary of Significant Accounting Policies

(a) Basis of Preparation

The financial statements are general purpose financial statements that have been prepared in accordance with the Australian Accounting Standards, Australian Accounting Interpretations and the *Associations Incorporation Act (ACT) 1981.*

Material accounting policies adopted in the preparation of these financial statements are presented below and have been consistently applied unless otherwise stated.

The financial statements have been prepared on an accruals basis and are based on historical costs, modified, where applicable, by the measurement at fair value of selected non current assets, financial assets and financial liabilities.

(b) Comparative Figures

When required by Accounting Standards, comparative figures have been adjusted to conform to changes in presentation for the current financial year.

Where the Association has retrospectively applied an accounting policy, made a retrospective restatement or reclassifies items in its financial statements, an additional statement of financial position as at the beginning of the earliest comparative period will be disclosed.

Notes to the Financial Statements *continued*

(c) Property, Plant and Equipment

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

Plant and equipment

Plant and equipment are measured on the cost basis less depreciation and impairment losses. Cost includes expenditure that is directly attributable to the asset.

The carrying amount of plant and equipment is reviewed annually by commitee members to ensure it is not in excess of the recoverable amount from these assets. The recoverable amount is assessed on the basis of the expected net cash flows that will be received from the asset's employment and subsequent disposal. The expected net cash flows have been discounted to their present values in determining recoverable amounts.

Depreciation

The depreciable amount of all fixed assets, is depreciated on a straight line basis over the asset's useful life commencing from the time the asset is held ready for use. Leasehold improvements are depreciated over the shorter of either the unexpired period of the lease or the estimated useful lives of the improvements.

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

Class of Fixed Asset	Depreciation Rate
Furniture, Fixtures and Fittings	5.00% - 10.00%
Office Equipment	10.00% - 33.33%

The assets' residual values, depreciation methods and useful lives are reviewed, and adjusted if appropriate, at the end of each reporting period.

An asset's carrying amount is written down immediately to its recoverable amount if the asset's carrying amount is greater than its estimated recoverable amount.

Gains and losses on disposals are determined by comparing proceeds with the carrying amount. These gains and losses are included in the statement of profit or loss and other comprehensive income. When revalued assets are sold, amounts included in the revaluation surplus relating to that asset are transferred to retained earnings.

(d) Financial Instruments

Initial recognition and measurement

Financial assets and financial liabilities are recognised when the entity becomes a party to the contractual provisions to the instrument. For financial assets, this is the equivalent to the date that the Association commits itself to either the purchase or sale of the asset (i.e. trade date accounting is adopted).

Financial instruments are initially measured at fair value plus transactions costs, except where the instrument is classified 'at fair value through profit or loss', in which case transaction costs are expensed to profit or loss immediately.

Classification and subsequent measurement

Financial instruments are subsequently measured at either of fair value, amortised cost using the effective interest rate method, or cost. *Fair value* represents the amount for which an asset could be exchanged or a liability settled, between knowledgeable, willing parties. Where available, quoted prices in an active market are used to determine fair value. In other circumstances, valuation techniques are adopted.

Amortised cost is calculated as:

(a) the amount at which the financial asset or financial liability is measured at initial recognition;

(b) less principal repayments;

(c) plus or minus the cumulative amortisation of the difference, if any, between the amount initially recognised and the maturity amount calculated using the *effective interest method*; and

(d) less any reduction for impairment.

The *effective interest method* is used to allocate interest income or interest expense over the relevant period and is equivalent to the rate that exactly discounts estimated future cash payments or receipts (including fees, transaction costs and other premiums or discounts) through the expected life (or when this cannot be reliably predicted, the contractual term) of the financial instrument to the net carrying amount of the financial asset or financial liability. Revisions to expected future net cash flows will necessitate an adjustment to the carrying value with a consequential recognition of an income or expense in profit or loss.

The Association does not designate any interest as being subject to the requirements of accounting standards specifically applicable to financial instruments.

(d) Financial Instruments *continued*

(i) Loans and receivables

Loans and receivables are non derivative financial assets with fixed or determinable payments that are not quoted in an active market and are subsequently measured at amortised cost .

Loans and receivables are included in current assets, except for those which are not expected to mature within 12 months after the end of the reporting period. (All other loans and receivables are classified as non current assets.)

(ii) Financial liabilities

Non derivative financial liabilities (excluding financial guarantees) are subsequently measured at amortised cost.

Fair value

Fair value is determined based on current bid prices for all quoted investments. Valuation techniques are applied to determine fair value for all unlisted securities, including recent arm's length transactions, reference to similar instruments and option pricing models.

Impairment

At each reporting date, the Association assesses whether there is objective evidence that a financial instrument has been impaired. In the case of available for sale financial instruments, a prolonged decline in the value of the instrument is considered to determine whether an impairment has arisen. Impairment losses are recognised in the statement of profit or loss and other comprehensive income.

Derecognition

Financial assets are derecognised where the contractual rights to receipt of cash flows expires or the asset is transferred to another party whereby the entity no longer has any significant continuing involvement in the risks and benefits associated with the asset. Financial liabilities are derecognised where the related obligations are either discharged, cancelled or expired. The difference between the carrying value of the financial liability extinguished or transferred to another party and the fair value of consideration paid, including the transfer of non cash assets or liabilities assumed is recognised in profit or loss.

(e) Impairment of Assets

At the end of each reporting period, the Association reviews the carrying values of its tangible and intangible assets to determine whether there is any indication that those assets have been impaired. If such an indication exists, the recoverable amount of the asset, being the higher of the asset's fair value less costs to sell and value in use, is compared to

the asset's carrying value. Any excess of the asset's carrying value over its recoverable amount is expensed to the statement of profit or loss and other comprehensive income.

Where it is not possible to estimate the recoverable amount of an individual asset, the Association estimates the recoverable amount of the cash generating unit to which the asset belongs.

(f) Cash and Cash Equivalents

Cash and cash equivalents include cash on hand, deposits held at call with banks, other short term highly liquid investments with original maturities of three months or less which are convertible to a known amount of cash and subject to an insignificant risk of change in value, and bank overdrafts. Bank overdrafts are shown within short term borrowings in current liabilities on the statement of financial position.

(g) Employee Benefits

Provision is made for the Association's liability for employee benefits arising from services rendered by employees to the end of the reporting period. Employee benefits that are expected to be settled within one year have been measured at the amounts expected to be paid when the liability is settled.

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. In determining the liability, consideration is given to employee wage increases and the probability that the employee may satisfy vesting requirements. Those cashflows are discounted using market yields on national government bonds with terms to maturity that match the expected timing of cashflows.

(h) Provisions

Provisions are recognised when the Association has a legal or constructive obligation, as a result of past events, for which it is probable that an outflow of economic benefits will result and that outflow can be reliably measured.

Provisions recognised represent the best estimate of the amounts required to settle the obligation at the end of the reporting period.

Notes to the Financial Statements *continued*

(i) Trade and other payables

Trade and other payables represent the liability outstanding at the end of the reporting period for goods and services received by the Association during the reporting period which remain unpaid. The balance is recognised as a current liability with the amounts normally paid within 30 days of recognition of the liability.

(j) Income Tax

The Association is exempt from income tax under Division 50 of the Income Tax Assessment Act 1997.

(k) Leases

Lease payments for operating leases, where substantially all of the risks and benefits remain with the lessor, are charged as expenses on a straight line basis over the life of the lease term.

(l) Revenue and Other Income

Revenue is measured at the fair value of the consideration received or receivable after taking into account any trade discounts and volume rebates allowed. Any consideration deferred is treated as the provision of finance and is discounted at a rate of interest that is generally accepted in the market for similar arrangements. The difference between the amount initially recognised and the amount ultimately received is interest revenue.

Interest revenue is recognised using the effective interest rate method, which for floating rate financial assets, is the rate inherent in the instrument.

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

(m) 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 Tax 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 the expense. Receivables and payables in the statement of financial position are shown inclusive of GST.

Cash flows are presented in the statement of cash flows on a gross basis, except for the GST component of investing and financing activities, which are disclosed as operating cash flows.

(n) Critical Accounting Estimates and Judgments

Key estimates – Impairment

The Association assesses impairment at the end of each reporting period by evaluating conditions specific to the Association that may be indicative of impairment triggers. Recoverable amounts of relevant assets are reassessed using value in use calculations which incorporate various key assumptions.

(o) New accounting standards for application in future periods

The AASB has issued new and amended Accounting Standards and Interpretations that have mandatory application dates for future reporting periods. The Association has decided against early adoption of these Standards . The following table summarises those future requirements, and their impact on the Association:

Standard Name	Effective Date for entity	Requirements	Impact
AASB 9 Financial Instruments and amending standards AASB 2010-7 / AASB 2012-6	30 June 2016	– Changes to the classification and measurement requirements for financial assets and financial liabilities. – New rules relating to derecognition of financial instruments.	The impact of AASB 9 has not yet been determined as the entire standard has not been released.
AASB 13 Fair Value Measurement. AASB 2011-8 Amendments to Australian Accounting Standards arising from AASB 13 [AASB 1, 2, 3, 4, 5, 7, 9, 2009 -11, 2010- 7, 101, 102, 108, 110, 116, 117, 118, 119, 120, 121, 128, 131, 132, 133, 134, 136, 138, 139, 140, 141, 1004, 1023 & 1038 and Interpretations 2, 4, 12, 13, 14, 17, 19, 131 & 132]	30 June 2014	AASB 13 provides a precise definition of fair value and a single source of fair value measurement and disclosure requirements for use across Accounting Standards but does not change when fair value is required or permitted. There are a number of additional disclosure requirements.	Fair value estimates currently made by the entity will be revised and potential changes to reported values may be required. The entity has not yet determined the magnitude of any changes which may be needed. Some additional disclosures will be needed.

(o) New accounting standards for application in future periods *continued*

Standard Name	Effective Date for entity	Requirements	Impact
AASB 119 Employee Benefits (September 2011) AASB 2011-10 Amendments to Australian Accounting Standards arising from AASB 119 (September 2011) and AASB 2011-11 Amendments to AASB 119 (September 2011) arising from Reduced Disclosure Requirements	30 June 2014	The main changes in this standard relate to the accounting for defined benefit plans and are as follows: – elimination of the option to defer the recognition of gains and losses (the 'corridor method'); – requiring remeasurements to be presented in other comprehensive income; and – enhancing the disclosure requirements.	Since the entity does not have a defined benefit plan, the adoption of these standards will not have any impact. OR Where the entity has a defined benefit plan, the impact of this standard should be calculated and disclosed.
AASB 2012-2 - Amendments to Australian Accounting Standards - Disclosures Offsetting Financial Assets and Financial Liabilities [AASB 132 & AASB 7]	30 June 2014	Requires the inclusion of information about the effect or potential effect of netting arrangements.	There is no impact on disclosures as there are no offsetting arrangements currently in place.

Standard Name	Effective Date for entity	Requirements	Impact
AASB 2012-5 Amendments to Australian Accounting Standards arising from Annual Improvements 2009-2011 Cycle [AASB 1, AASB 101, AASB 116, AASB 132 & AASB 134 and Interpretation 2]	30 June 2014	AASB 1 this standard clarifies that an entity can apply AASB 1 more than once. AASB 101 clarifies that a third statement of financial position is required when the opening statement of financial position is materially affected by any adjustments. AASB 116 clarifies the classification of servicing equipment. AASB 132 and Interpretation 2 Clarifies that income tax relating to distributions to holders of an equity instrument and to transaction costs of an equity transaction shall be accounted for in accordance with AASB 112 Income Taxes AASB 134 provides clarification about segment reporting.	No expected impact on the entities financial position or performance.

(o) New accounting standards for application in future periods *continued*

Standard Name	Effective Date for entity	Requirements	Impact
AASB 2011-12 Amendments to Australian Accounting Standards arising from Interpretation 20	30 June 2014	Allows transitional provisions for strippings costs in accordance with Interpretation 20.	There will be no impact as entity is not in the mining industry.
AASB 2012-9 Amendment to AASB 1048 arising from the Withdrawal of Australian Interpretation 1039	30 June 2014	Removes reference to withdrawn Interpretation 1039	No impact on the financial statements.
AASB 2012-3 Amendments to Australian Accounting Standards Offsetting Financial Assets and Financial Liabilities [AASB 132]	30 June 2015	This standard adds application guidance to AASB 132 to assist with applying some of the offset criteria of the standard.	There will be no impact to the entity as there are no offsetting arrangements currently in place.

3 Revenue and Other Income

	$ 2013	$ 2012
Sales revenue		
– Scholarship Grant	**46,200**	-
– Conference Grant	**248,826**	-
– DoHA Grant	**1,216,663**	864,873
	1,511,689	864,873
Other revenue		
– Interest revenue	**10,680**	7,816
– Services Rendered	**1,980**	1,118
– Donations	**4,400**	-
– Sale of items	**2,976**	-
	20,036	8,934
Total Revenue	**1,531,725**	873,807

4 Cash and Cash Equivalents

	$ 2013	$ 2012
Cash at bank	146,033	146,132
Investment account	65,201	17,150
Rental Bond	17,094	-
Cash on Hand	298	166
	228,626	163,448

Reconciliation of cash

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

	$ 2013	$ 2012
Cash and cash equivalents	228,626	163,448

5 Trade and Other Receivables

	$ 2013	$ 2012
CURRENT		
Trade receivables	-	3,774
Total current trade and other receivables	-	3,774

Credit risk

The Association has no significant concentration of credit risk with respect to any single counterparty or group of counterparties other than those receivables specifically provided for and mentioned within Note 5. The main source of credit risk to the Association is considered to relate to the class of assets described as 'trade and other receivables'.

The following table details the Association's trade and other receivables exposure to credit risk (prior to collateral and other credit enhancements) with ageing analysis and impairment provided for thereon. Amounts are considered as 'past due' when the debt has not been settled, with 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 is objective evidence indicating that the debt may not be fully repaid to the Association.

5 Trade and Other Receivables *continued*

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

2012	$ Gross Amount	$ Past due and impaired	$ < 30	$ 31-60	$61-90	$ > 90	$ Within initial trade terms
Trade and term receivables	3,774	-	3,300	474	-	-	-
Total	3,774	-	3,300	474	-	-	-

The Association does not hold any financial assets with terms that have been renegotiated, but which would otherwise be past due or impaired.

The other classes of receivables do not contain impaired assets.

6 Property, Plant and Equipment

	$ 2013	$ 2012
Furniture, fixture and fittings		
At cost	**38,330**	10,915
Accumulated depreciation	**(3,294)**	(2,452)
Total furniture, fixture and fittings	**35,036**	8,463
Office equipment		
At cost	**48,089**	36,947
Accumulated depreciation	**(24,756)**	(17,217)
Total office equipment	**23,333**	19,730
Total property, plant and equipment	**58,369**	28,193

(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:

	$ Furniture, Fixtures and Fittings	$ Office Equipment	$ Total
Balance at the beginning of year	8,463	19,730	28,193
Additions	33,457	15,413	48,870
Disposals	(4,650)	(645)	(5,295)
Depreciation expense	(2,234)	(11,165)	(13,399)
Balance at 30 June 2013	**35,036**	**23,333**	**58,369**

7 Other Assets

	$ 2013	$ 2012
CURRENT		
Prepayments	**38,384**	33,133

8 Trade and Other Payables

	$ 2013	$ 2012
CURRENT		
Trade Payables	**42,912**	27,530

(a) Financial liabilities at amortised cost classified as trade and other payable

	Note	$ 2013	$ 2012
Trade and other payables			
– Total current		42,912	27,513
Financial liabilities as trade and other payables	12	42,912	27,513

9 Short term Provisions

	$ 2013	$ 2012
CURRENT		
Provision for annual leave	**44,115**	25,902
Total provision	**44,115**	25,902

Notes to the Financial Statements *continued*

10 Other Financial Liabilities

	$ 2013	$ 2012
CURRENT		
Health Systems Grant	**50,000**	-
IAHA Conference Sponsors	**40,727**	24,727
RHCE Grant	**-**	27,720
IAHA Conference Grant	**145,455**	100,000
IAHA Conference Registration	**-**	1,618
Total	**236,182**	154,065

11 Capital and Leasing Commitments

Operating Lease Commitments

Non cancellable operating leases contracted for but not capitalised in the financial statements

	$ 2013	$ 2012
Payable minimum lease payments:	**64,025**	67,106
– not later than 12 months	**64,025**	67,106

Operating leases have been have been taken out for rental accomodation in Canberra. Lease payments are increased on an annual basis to reflect market rentals.

12 Financial Risk Management

The main risks Indigenous Allied Health Australia Incorporated is exposed to through its financial instruments are credit risk, liquidity risk and market risk consisting of interest rate risk.

The Association's financial instruments consist mainly of deposits with banks, local money market instruments, short term investments, accounts receivable, accounts payable and leases.

The totals for each category of financial instruments, measured in accordance with AASB 139 as detailed in the accounting policies to these financial statements, are as follows:

	$ 2013	$ 2012
Financial Assets		
Cash and cash equivalents	228,626	163,448
Total Financial Assets	**228,626**	**163,448**
Financial Liabilities		
Financial liabilities at amortised cost		
– Trade and other payables	42,912	27,531
Total Financial Liabilities	**42,912**	**27,531**

Financial Risk Management Policies

The Board has overall responsibility for the establishment of Indigenous Allied Health Australia Incorporated's financial risk management framework. This includes the development of policies covering specific areas such as interest rate risk and credit risk. Risk management policies and systems are reviewed regularly to reflect changes in market conditions and Indigenous Allied Health Australia Incorporated's activities.

The day to day risk management is carried out by Indigenous Allied Health Australia Incorporated's finance function under policies and objectives which have been approved by the Board. The Chief Financial Officer has been delegated the authority for designing and implementing processes which follow the objectives and policies. This includes monitoring the levels of exposure to interest rate risk and assessment of market forecasts for interest rate.

The Board receives monthly reports which provide details of the effectiveness of the processes and policies in place.Indigenous Allied Health Australia Incorporated does not actively engage in the trading of financial assets for speculative purposes.

Mitigation strategies for specific risks faced are described below:

(a) Credit risk

Exposure to credit risk relating to financial assets arises from the potential non performance by counterparties of contract obligations that could lead to a financial loss to Indigenous Allied Health Australia Incorporated and arises principally from Indigenous Allied Health Australia Incorporated's receivables.

12 Financial Risk Management *continued*

It is Indigenous Allied Health Australia Incorporated's policy that all customers who wish to trade on credit terms undergo a credit assessment process which takes into account the customer's financial position, past experience and other factors. Credit limits are then set based on ratings in accordance with the limits set by the Board, these limits are reviewed on a regular basis.

Credit risk exposures

The maximum exposure to credit risk by class of recognised financial assets at the end of the reporting period, excluding the value of any collateral or other security held, is equivalent to the carrying value and classification of those financial assets (net of any provisions) as presented in the statement of financial position.

No collateral is held by Indigenous Allied Health Australia Incorporated securing receivables

The Association has no significant concentration of credit risk with any single counterparty or group of counterparties. Details with respect to credit risk of Trade and Other Receivables are provided in Note 5.

Trade and other receivables that are neither past due or impaired are considered to be of high credit quality. Aggregates of such amounts are as detailed at Note 5.

Credit risk related to balances with banks and other financial institutions is managed by a policy requiring that surplus funds are only invested with counterparties with a Standard and Poor's rating of at least AA . The following table provides information regarding credit risk relating to cash and money market securities based on Standard & Poor's counter party credit ratings.

	$ 2013	$ 2012
Cash and cash equivalents		
– AA Rated	**228,626**	163,448

(b) Liquidity risk

Liquidity risk arises from the possibility that Indigenous Allied Health Australia Incorporated 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 financial activities which are monitored on a monthly basis;
- monitoring undrawn credit facilities;
- obtaining funding from a variety of sources;
- maintaining a reputable credit profile;
- managing credit risk related to financial assets;
- only investing surplus cash with major financial institutions; and
- comparing the maturity profile of financial liabilities with the realisation profile of financial assets.

Typically, Indigenous Allied Health Australia Incorporated ensures that it has sufficient cash on demand to meet expected operational expenses for a period of 60 days.

The available funds to the Group are discussed in note 16.

(c) Market risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices.

i. Interest rate risk

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

The Association is not exposed to any significant interest rate risk.

Net Fair Values

Fair value estimation

The fair values of financial assets and financial liabilities are presented in the following table and can be compared to their carrying values as presented in the statement of financial position. Fair values are those amounts at which an asset could be exchanged, or a liability settled, between knowledgeable, willing parties in an arm's length transaction.

12 Financial Risk Management *continued*

(c) Market risk *continued*

Fair values derived may be based on information that is estimated or subject to judgment, where changes in assumptions may have a material impact on the amounts estimated. Areas of judgment and the assumptions have been detailed below. Where possible, valuation information used to calculate fair value is extracted from the market, with more reliable information available from markets that are actively traded. In this regard, fair values for listed securities are obtained from quoted market bid prices. Where securities are unlisted and no market quotes are available, fair value is obtained using discounted cash flow analysis and other valuation techniques commonly used by market participants.

	2013		2012	
	$ Net Carrying Value	$ Net Fair Value	$ Net Carrying Value	$ Net Fair Value
Financial Assets				
Cash and cash equivalents	228,626	228,626	163,448	163,448
Trade and other receivables	-	-	3,774	3,774
Total financial assets	**228,626**	**228,626**	**167,222**	**167,222**
Financial Liabilities				
Trade and other payables	42,912	42,912	27,531	27,531
Total financial liabilities	42,912	42,912	27,531	27,531

13 Profit for the Year

(a) Expenses

	$ 2013	$ 2012
Interest expense on financial liabilities not at fair value through profit or loss:		
– external	824	1,003
Total interest expense	824	1,003
Other interest expenses:		
– Occupancy costs	63,500	32,285
Auditing or reviewing the financial report	7,500	7,000

14 Auditors' Remuneration

	$ 2013	$ 2012
Remuneration of the auditor of the Association for:		
– auditing or reviewing the financial statements	**7,500**	7,000

15 Related Party Transactions

(a) Other Related Parties

The board members are as stated in the "Board Member's Report". No related party transaction occurred that require disclosure.

16 Cash Flow Information

(a) Reconciliation of result for the year to cashflows from operating activities

Reconciliation of net income to net cash provided by operating activities:

	$ 2013	$ 2012
Profit for the year	**(18,882)**	37,956
Cash flows excluded from profit attributable to operating activities		
Non cash flows in profit:		
– depreciation	**13,399**	8,850
Changes in assets and liabilities, net of the effects of purchase and disposal of subsidiaries:		
– (increase)/decrease in trade and other receivables	**3,774**	(3,470)
– (increase)/decrease in prepayments	**(5,251)**	(27,796)
– increase/(decrease) in income in advance	**83,735**	(74,826)
– increase/(decrease) in trade and other payables	**13,765**	(38,462)
– increase/(decrease) in provisions	**18,212**	(3,529)
Cashflow from operations	**108,752**	(101,277)

Notes to the Financial Statements *continued*

17 Events After the End of the Reporting Period

No events have occured after balance date that would significantly affect the future operations or financial position of the association.

18 Association Details

The registered office and principal place of business of the association are:

Indigenous Allied Health Australia Inc.
6b Thesiger Court
Deakin ACT 2600

Statement by Members of the Board

In the opinion of the board the financial report as set out on pages 50 to 70:

1. Present fairly the financial position of Indigenous Allied Health Australia Incorporated as at 30 June 2013 and its performance for the year ended on that date in accordance with Australian Accounting Standards (including Australian Accounting Interpretations) of the Australian Accounting Standards Board.

2. At the date of this statement, there are reasonable grounds to believe that Indigenous Allied Health Australia Incorporated will be able to pay its debts as and when they fall due.

This statement is made in accordance with a resolution of the board and is signed for and on behalf of the board by:

Director:

Faye Mcmillan

Director:

Keona Wilson

Dated: 16 August 2013

Independent Auditor's Report

Report on the Financial Report

We have audited the accompanying financial report of Indigenous Allied Health Australia Incorporated, which comprises the statement of financial position as at 30 June 2013, the statement of profit or loss and other comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and management's assertion statement.

Management's Responsibility for the Financial Report

Management is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the Associations Incorporation Act 1981, and for such internal control as management determines is necessary to enable the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error.

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. Those standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance about 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 judgement, 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 control 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 control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, 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.

Opinion

In our opinion, the financial report presents fairly, in all material respects, the financial position of Indigenous Allied Health Australia Incorporated as at 30 June 2013, and its financial performance and its cash flows for the year then ended in accordance with Australian Accounting Standards and the Associations Incorporation Act 1981.

Emphasis of Matter

We draw attention to Note 1 of the financial statements which describe the Change in operational sturcture.

Our opinion is not qualified in respect of this matter.

Hardwickes

Hardwickes Chartered Accountants

Robert Johnson FCA

Chartered Accountants

Canberra

16 August 2013


Aboriginal Hostels Limited


IAHA
Indigenous Allied Health Australia
National Conference

“We’ve got a voice now, a body who will advocate for us and support us in our professions.”

- Daniel Jopp, Bachelor of Health Science (Mental Health) student

6b Thesiger Court Deakin West ACT 2600
PO Box 323 Deakin West ACT 2600
Phone: +61 2 6285 1010
Fax: +61 2 6260 5581
www.iaha.com.au