Annual Report 2013–2014

Consumers Health Forum
of Australia

representing
consumers
on national
health issues

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Publication information:

Consumers Health Forum of Australia

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ISSN 1324-5392

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MISSION

The Consumers Health Forum of Australia (CHF) is the national peak body representing the interests of Australian healthcare consumers. CHF works to achieve safe, quality, timely healthcare for all Australians, supported by accessible health information and systems.

CHF does this by:

1. advocating for appropriate and equitable healthcare
2. undertaking consumer-based research and developing a strong consumer knowledge base
3. identifying key issues in safety and quality of health services for consumers
4. raising the health literacy of consumers, health professionals and stakeholders
5. providing a strong national voice for health consumers and supporting consumer participation in health policy and program decision making.

VALUES

CHF member organisations reach Australian health consumers across a wide range of health interests and health system experiences. CHF policy is developed through consultation with members, ensuring that CHF maintains a broad, representative, health consumer perspective.

CHF is committed to being an active advocate in the ongoing development of Australian health policy and practice.

CHF values:

- our members' knowledge, experience and involvement
- development of an integrated healthcare system that values the consumer experience
- prevention and early intervention
- collaborative integrated healthcare
- working in partnership.

REPORT FROM CHAIR

The past year has proved a time of significant change for Australia's health consumers and for CHF itself. The election of the Coalition Government has resulted in the prospect of quite drastic change that could impact negatively on consumers. The budget plans for a co-payment and an increase in PBS charges, the creation of Primary Health Networks replacing Medicare Locals and the tentative extension of health insurance funds into primary medical care, all have central repercussions for a universal and equitable health system espoused by CHF.

We have argued that the Government needs to re-orient the health system. What worked 40 years ago does not work now. We need to look at health funding structures including MBS, which rewards throughput, rather than health outcomes. CHF has started to develop principles of consumer-centred healthcare so that we can all work towards achieving this goal.

In August before the federal election, CHF led the *Mend Medicare* coalition to campaign for both sides of politics to give more attention to rising inequities in health. CHF also co-sponsored with the National Press Club, the election health debate between then Health Minister, Tanya Plibersek and then Shadow Health Minister, Peter Dutton.

CHF continues to challenge government assertions about the unsustainability of the health system. Our campaign on out-of-pocket costs is an example of how we have sought to take a proactive stance in shedding light on the impact of co-payments, such as the report by Jennifer Doggett we commissioned, the consumer survey of almost 1000 people across the country and the "Better Bang for the Buck" edition of *Health Voices* which published a range of expert proposals for improving health value for money. Our research and submissions were presented to various parliamentary inquiries and distributed to federal MPs.

Consumer stories have played a major role in the way we have argued our point – behind every statistic is a human story. We take this a step further – consumer stories backed up by the evidence. We are proud of our work to give legitimacy to consumer stories as a form of evidence, particularly in the decision-making process. The *Real People, Real Data* project exemplifies this. We have even used this to inform a national funding decision via the independent MSAC process.

A board priority has been to develop member engagement, generating opportunities through personal contact and through an active web site for members to get involved in CHF's work and for members to provide feedback on our Strategic Plan and our organisation's future direction.

CHF has also experienced a number of changes at the board and senior staffing levels with the departures of chair, Karen Carey and CEO Carol Bennett, both of whom made a tremendous contribution in lifting the profile of CHF and its influence in health policy-making. I was elected unopposed by the Board as the new Chair and our new CEO, Adam Stankevicius, took up the post at a challenging time, having almost immediately to respond to media responses to our co-payments report.

While the challenges facing the health sector are enormous CHF stands ready to work collaboratively with health consumers, our members, our stakeholders, the Federal Government and the health providers to improve the viability and sustainability of the health system for all health consumers.

Tony Lawson
Chair

REPORT FROM CEO

Dear Members

It is a great privilege to lead the CHF team, and I must begin by acknowledging my predecessors, who shared stewardship of the CHF secretariat during 2013-14: Carol Bennett and Rebecca Vassarotti. Carol's dedication to CHF and the consumer movement is evident in all that the organisation does and what it has achieved over the past five years. Rebecca, while only being with CHF for a short period, brought vitality, commitment and compassion to the secretariat. The organisation is indebted to them both.

Of course, any CEO can only succeed with the support of a dedicated staff team, and CHF is very lucky to have a team of great knowledge, experience and strength. During the year, we achieved a significant amount with, and for, health consumers because we have such a great team. But every team member is also on their own journey, and during the year we farewelled Deb, Maiy, Carlo, and Laura, who left CHF to pursue other opportunities. We sincerely thank them for their contribution to CHF.

We would not be able to effectively be a voice for health consumers, if we did not have them and their representative organisations as members. CHF's public policy integrity is drawn from the contribution of its membership base. Since February 2014, when I joined the organisation, I have met many of you, and heard many, many consumer stories of hardship and perseverance, courage and dedication, good times and bad times, feelings of elation and sadness. I sincerely thank you all for sharing those stories, as not only do they enrich us as a consumer organisation, and as a consumer movement, but they also put a very human face on the experiences we represent in the corridors of policy, politics and power. We should never underestimate the value of the consumer story.

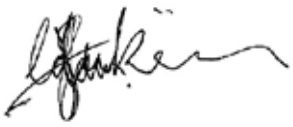
This report details the extraordinary achievements of our dedicated secretariat across membership services, support for consumer representatives, policy development, commissioned project work, consumer surveys, publications and websites, media and campaigns, and corporate services.

In particular, we feature two highly significant pieces of work undertaken by the secretariat this year: the development of the *Real People, Real Data* Toolkit and Patient Journey Wheel, and our commissioned research on co-payments in healthcare. Both of these pieces of work have had significant impact on the way we have been able to shape the consumer debate around key issues. *Real People, Real Data* is a revolutionary way to improve the robustness of the presentation of the consumer experience, while the co-payments research positioned us very well to respond to the Federal Government's 2014-15 budget proposals on Medicare co-payments.

We have also continued our high volume production of policy submissions, media releases and appearances, as well consumer representative nominations and support. These are all detailed further in the following sections.

Finally, can I thank the amazing members of the CHF Board, who have provided guidance and support to the various CEOs during the year, while also be impacted upon by significant changes in their own composition. Their insights and contribution are an essential part of what makes CHF so effective.

I look forward to working with you, hearing more of your stories and celebrating more successes for the health consumer movement in 2014-15!



Adam Stankevicius
Chief Executive Officer

HIGHLIGHTS & ACHIEVEMENTS

POLICY

In the past year, CHF has provided more than 100 submissions and policy documents to health policy consultations. CHF routinely draws on our network of members, consumer representatives and consumers to ensure a consumer-centred approach to our policy positions. This ensures that CHF's advice highlights the aspects that are most important to consumers, including accessible and affordable care; coordinated and comprehensive care; appropriate care; whole-of-person care; informed decision making; and trust and respect.

CHF ensures that our policies and priorities reflect a sound evidence base by incorporating into our submissions consumer evidence obtained through qualitative and quantitative methods such as consultations, focus groups and surveys. We also draw on robust national and international data and academic literature.

These submissions covered a wide range of health issues. The top 6 issues CHF has responded to include:

1. Pharmaceuticals and therapeutic goods

Establishing a single code of conduct for the promotion of therapeutic goods would provide the Australian community and health consumers with reassurance that the promotion of medicines and other therapeutic goods is ethical, competitive, transparent and ultimately done for the public benefit.

Extract from CHF's submission to the Australian Government's Competition Policy Review, June 2014

2. Health reform

CHF does not accept that there is an inevitable growth in costs which require more government investment in health, or that any growth should be funded through increased consumer co-payments and higher out-of-pocket costs. There are currently significant opportunities to improve health outcomes and structural efficiency within the health care system. Improving efficiency through more effective community/primary care interventions and reducing unnecessary payments in areas such as pharmaceuticals, should deliver the financial capacity to reduce (not grow) out-of-pocket costs for consumers.

Extract from CHF's submission to the Inquiry into Out-of-pocket costs in Australian healthcare, May 2014

3. Safety and Quality

International experience demonstrates that the success of any health literacy campaign is dependent upon the ability of stakeholders to develop and sustain a centralised effort and to have faith in the tools being utilised to measure health literacy. These are not particularly difficult barriers to overcome. Broad agreement already exists on what constitutes health literacy, several examples of successful health literacy campaigns exist, and there has been considerable research into tools to promote and evaluate health literacy. The challenge is identifying what will work for Australia, establishing clear goals and measures to track health organisations' progress in meeting them, and ensuring that consumers are part of the discussion.

Extract from CHF's submission to the Australian Commission on Safety and Quality in Health Care's discussion paper, Consumers, the health system and health literacy: Taking action to improve safety and quality, September 2013

4. Medical benefits

In CHF's view, it is clear that the overall effect of abolishing the Net Medical Expenses Tax Offset (NMETO) and the restrictions placed on the Extended Medicare Safety Net would be to disproportionately impact on vulnerable healthcare consumers, which may further impact on people delaying, or not seeking treatment for their health conditions. In the absence of any measures to alleviate rising out-of-pocket costs for consumers following the proposed abolition of the NMETO, and given the Medicare Safety Net's function as the primary support mechanism for medical expenses, CHF reiterates its call for an inquiry into Medicare to ensure that it continues to meet its objectives of providing sustainable and affordable healthcare to all Australians.

Extract from CHF's submission to the Treasury on the exposure draft legislation to implement the phase-out of the NMETO, January 2014

5. Pharmacy

It is misleading to contend that the Government is obliged to pay inflated costs for drugs to support the profitability of pharmacies. It was never the intention of pharmaceutical pricing to fund anything other than the cost of the drug.

Extract from CHF's supplementary submission to the Australian National Audit Office's Performance Audit of the Administration of the Fifth Community Pharmacy Agreement, August 2013

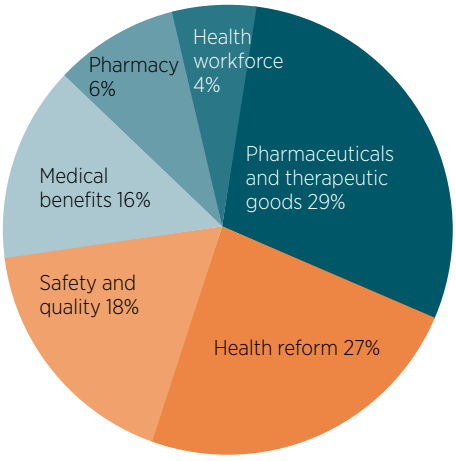
6. Health workforce (including health practitioner regulation)

Given that accredited dental practitioners will form the majority of consumers' interactions with the dental healthcare system, CHF considers it vital that the Standards promote consumer-centric care. CHF therefore strongly recommends that Australian Dental Council enhance and strengthen consumer representation and engagement through their work.

Extract from CHF's submission to the Review of Accreditation Standards for Dental Practitioner Programs being undertaken by the Australian Dental Council, May 2014

CHF's submissions are available on the CHF website https://www.chf.org.au/submissions.php

The top six issues CHF has responded to from 1 July 2013 to 30 June 2014



PARLIAMENTARY INQUIRIES

CHF has continued to advocate for consumers at the highest levels of government through significant national parliamentary inquiries.

CHF is routinely invited to present evidence at the public hearings, and our submissions are often cited by parliamentary reports.

Examples of CHF's involvement in parliamentary inquiries with a national health focus include:

- Submission to the Senate Inquiry into the Health Workforce Australia (Abolition) Bill 2014
- Submission to the Senate Inquiry into the Australian National Preventive Health Agency (Abolition) Bill 2014
- Submission to the Senate Inquiry into Out-of-pocket costs in Australian healthcare
- Submission to the Senate Inquiry into Health Insurance Amendment (Extended Medicare Safety Net) Bill 2014
- Submission to the Senate Inquiry into the Commission of Audit

SURVEYS

CHF conducts consumer surveys as one way of ensuring that consumer perspectives are reflected in our policy positions. CHF circulates the consumer surveys to our network of consumers, consumer organisations and members. We use the *OurHealth* website and our social media platforms to promote the survey to consumers who may not have strong links to a health consumer organisation or network.

In the past year, CHF conducted five major consumer surveys.

Survey to inform Consumer and Community Input into the Review of Funding Arrangements for Chemotherapy Services

This survey provided an opportunity for consumers to contribute to the CHF consultations on the funding arrangements for chemotherapy services. While the results were largely consistent with the views expressed in face to face consultations and tele-consultations, there was more variety in responses. The results provided strong insights into the experiences and views of health consumers who have accessed chemotherapy services.

Survey to inform the NPS Decision Support as a Service (DSaaS) project (part of CHF's NPS Information Prescriptions Project)

This survey was conducted to identify broad-level consumer perspectives and themes on GP Care Management Plans. Consumers who had received a care management plan from their GP were broadly satisfied with their plans. However, the results indicated that what consumers valued more than the plan itself was the ability it provided to have a conversation with their GP. The take-away message for GPs is that they should take more time with their patients to discuss the strategy for managing their conditions and ensure that they explain why the course of treatment will be effective. CHF recommends that GPs use a "teach-back" method with their patients to ensure that they fully understand the contents of the plan and can adhere to it.

Health Consumer Out-of-Pocket Costs Survey

This survey provided a valuable look at the impact of out-of-pocket costs on consumers. The results show that half are paying in excess of $1,000 per year, with almost one-third of consumers delaying necessary health treatments in order to avoid costs. As general practitioners remain the primary point of access for consumers, recent proposals to increase co-payments for visits to GPs will have deep, negative impacts on consumers across the health care spectrum.

The survey results show that private health insurance provides no relief from high out-of-pocket costs, and in fact exacerbates the situation by adding expensive health insurance premiums on top of health costs. These expenses are putting significant strains on the consumer's day-to-day living by decreasing the quality of their health, introducing stress and anxiety, and forcing consumers to make choices between their health and other necessary expenses.

'Selected Health Occupations' Survey

This survey provides a number of valuable insights to consumers' experiences with specialist health care occupations. A high number of consumers are seeking or have sought treatment from health care specialists. While a majority of survey respondents did not indicate any difficulty being able to locate a specialist near their home, those who have sought care did report some barriers to access. Cost remains the most significant barrier to consumers being able to access specialists, regardless of their availability in either urban or rural settings. Consumers with a higher level of private health insurance appear not to view costs as a barrier relative to other consumers. Wait times to see specialists can be lengthy, but many consumers feel that they are being seen by specialists within a reasonable amount of time.

HWA Oral Health Survey

CHF assisted Health Workforce Australia (HWA) to hear consumer views on the availability of, and access to, dental services across Australia. Consumer input was used by HWA to inform its "Health Workforce 2025 – Oral Health" projects, which evaluate workforce supply and demand to support national, state and territory policy decisions to improve oral healthcare.

PROJECT WORK

Real People, Real Data Project

CHF was funded by the Australian Government Department of Health to deliver the *Real People, Real Data* Project. The Project sustains and leverages the foundation established by the CHF *Our Health, Our Community* Project 2010-13 to strengthen the consumer voice in health decision-making.

A key achievement of the Project is the development and piloting of a best-practice method and tool for capturing and analysing essential information about patient journeys – as related by patients – to contribute more systematically and effectively to evidence-based decision-making in health.

A Health Experience Wheel captures some aspects of a person's healthcare journey, which can be analysed against a particular stage of the journey, or against consumer-centred care indicators.

The Project has three activity components:

- **Part A:** Research, capture and analyse consumer experiences to develop a means to include objective, holistic data about consumer experience in decision-making. This will result in the development, piloting and evaluation of the *Real People, Real Data* toolset.
- **Part B:** Build a knowledge bank of consumer information that can be shared and used to support more effective decision-making via the CHF *OurHealth* website. The *Real People, Real Data* Project will enable the website to share a toolset that further facilitates the capture and use of objective consumer data in health decision-making.
- **Part C:** Provide support and development to sustain consumer engagement and effective, constructive consumer involvement in health reform.

The *Real People, Real Data* method and tool were tested through practical implementation by organisations representative of the anticipated users of the toolkit: health services, health policy agencies and health consumer organisations.

The experience of the organisations involved in the pilot, as reflected in an external evaluation conducted as part of the Project, demonstrate that the *Real People, Real Data* toolkit supports a robust approach to collecting consumer experience narratives, and that the Health Experience Wheel analysis and data presentation tool contribute to the effective measurement of quality health outcomes.

The *Real People, Real Data* toolkit will be made freely available on the *OurHealth* website. Consumers will also be able to generate their own Patient Experience Wheel on the website at no cost.

The *Real People, Real Data* project also supported the further development of the *OurHealth* website as a forum for people to share ideas and experiences to improve the Australian healthcare system. Since July 2013, 80 detailed stories have been added to the 'Consumer Stories' section, and consumer conversation in the 'Have a say' forum has continued to canvass a wide range of health system experience. Consumer use of *OurHealth* social media channels has also grown during the reporting period. The *OurHealth* Facebook page has been very effective in encouraging consumer conversation about a variety of health issues.

The Project has also supported consumer engagement and constructive consumer participation in health reform. This has included by making available a variety of online training and information resources available on the *OurHealth* website to support consumer and community advocates working at every level of the health system. These include:

- A consumer representative 'Orientation Training' module
- An information module on Consumer and Community engagement
- A guide to the Health System for Consumer Advocates.
- A guide to Informed Consent and information about the value of sharing a story for health system improvement.

CHF convened a Health Consumer and Community Leaders' Workshop in Canberra on 11 September 2013. This was the last in a series of workshops held nationally to provide

professional development, networking and knowledge sharing to assist consumer and community members in their roles on boards and advisory committees. One of the workshop sessions was devoted to seeking input and guidance on the development of the *Real People, Real Data* project.

Further feedback on the project was sought during a national workshop with consumer representatives, in Melbourne on 29-30 April 2014. The first day was co-hosted by members of the Pharmaceutical Benefits Advisory Committee (PBAC) and provided an insight into the PBAC's evidence-based processes. In addition to sharing information about a changing health policy context and seeking feedback on the CHF consumer representatives program, on the second day CHF member organisations involved in the Real People Real Data pilot presented their experiences. Feedback and discussion assisted in finalising the Real People Real Data resources.

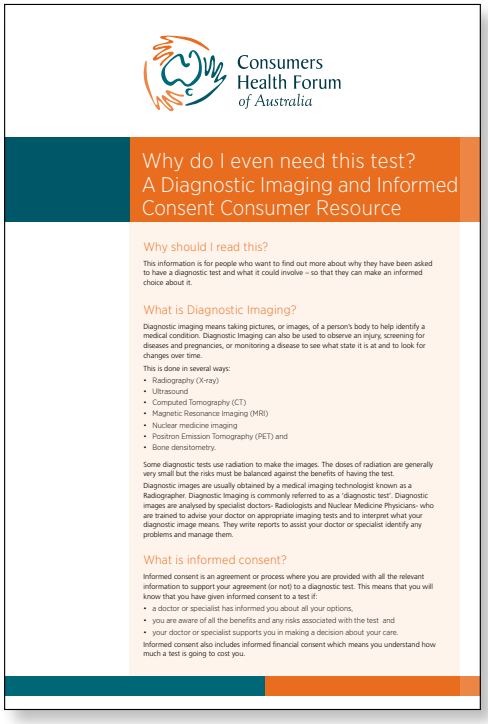
Diagnostic Imaging and Informed Consent Project

The overarching aim of the Project is to inform and consult with consumers about current diagnostic imaging practice. The aim of the Project was achieved through extensive consultation with consumers at a national level. Consultations with consumers included the development of a *Diagnostic Imaging and Informed Consent Information Paper* to which consumers were invited to respond, three consultative teleconferences, a national consumer workshop and a national focus group. These consultations facilitated consumer input on the quality use of diagnostic imaging and enabled the identification of strategies to improve quality use of diagnostic imaging.

The main objective of the Project was to explore consumer perspectives and experiences on diagnostic imaging to inform the development of a consumer resource. The resource was guided by the feedback of consumers, and provides key information on:

- informed consent and informed financial consent;
- important questions to ask before undergoing testing; and
- where to go for more information.

The resource was widely circulated to CHF members and is freely available at https://www.chf.org.au/pdfs/chf/Diagnostic-imaging-factsheet_WEB.pdf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Why do I even need this test?
A Diagnostic Imaging and Informed Consent Consumer Resource

Why should I read this?

This information is for people who want to find out more about why they have been asked to have a diagnostic test and what it could involve – so that they can make an informed choice about it.

What is Diagnostic Imaging?

Diagnostic imaging means taking pictures, or images, of a person's body to help identify a medical condition. Diagnostic Imaging can also be used to observe an injury, screening for diseases and pregnancies, or monitoring a disease to see what state it is at and to look for changes over time.

This is done in several ways:

- Radiography (X-ray)
- Ultrasound
- Computed Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Nuclear medicine imaging
- Positron Emission Tomography (PET) and
- Bone densitometry.

Some diagnostic tests use radiation to make the images. The doses of radiation are generally very small but the risks must be balanced against the benefits of having the test.

Diagnostic images are usually obtained by a medical imaging technologist known as a Radiographer. Diagnostic Imaging is commonly referred to as a 'diagnostic test'. Diagnostic images are analysed by specialist doctors- Radiologists and Nuclear Medicine Physicians- who are trained to advise your doctor on appropriate imaging tests and to interpret what your diagnostic image means. They write reports to assist your doctor or specialist identify any problems and manage them.

What is informed consent?

Informed consent is an agreement or process where you are provided with all the relevant information to support your agreement (or not) to a diagnostic test. This means that you will know that you have given informed consent to a test if:

- a doctor or specialist has informed you about all your options,
- you are aware of all the benefits and any risks associated with the test and
- your doctor or specialist supports you in making a decision about your care.

Informed consent also includes informed financial consent which means you understand how much a test is going to cost you.

Consumer Education and Support for Medical Benefits Issues Project 2013–14

The aim of the Project is to educate and support consumers about the issues surrounding access to medical services, to act for consumers in interactions with the Medical Services Advisory Committee (MSAC) and any related committees, and to provide input on policy areas examining medical services.

The Project enabled consumer input into the MSAC process through:

- The provision of consumer submissions during the MSAC public consultation stage
- The development of consumer-specific tools (templates) and resources (factsheets) designed to increase consumer participation during MSAC consultations
- The provision of training, structure to prepare for meetings, information and population data to support the participation of consumer representatives across

MSAC committees consistent with international best-practice approaches

- The delivery of consumer-specific workshops to increase understanding of the MSAC process among consumer groups and community members.

A key highlight of the Project has been the development and use of the *Real People, Real Data* tool in the MSAC decision-making process. The tool provided MSAC consumer representatives with access to consumer evidence in the form of consumer stories (experiences) supported by a rigorous methodology and validated against consumer-centred indicators.

NPS Information Prescriptions Project

CHF continued our longstanding collaboration with NPS in 2013-14. The Project's key tasks were met through consultation with consumers at a national level with a key focus on providing input to the *NPS Decision Support as a Service (DSaaS) project.*

CHF undertook consumer research with people who currently use a care management plan to inform the design of a new consumer-centric care management plan and experience. The research aimed to learn about the people who use care management plans, how and why they use them or not, and the role care plans could take in addressing their pain points.

The scope of the research was healthcare and chronic disease management. However CHF also explored other areas to understand the non-health care impacts and other pain points in managing chronic conditions and the role a care plan might have in supporting consumers.

Through this research, consumers highlighted that while their plans serve a valuable purpose, they could be enhanced through taking a more consumer-centred approach to the design and delivery aspects of the plan. This would result in a plan that helps consumers take action towards better health outcomes by enabling greater partnership with their health practitioner and greater engagement in the decision-making process.

Provision of Consumer Input into Health Workforce Australia's Initiatives and Programs 2013

CHF worked with Health Workforce Australia (HWA) in 2013-14 to facilitate and provide consumer perspectives on HWA's projects. This work included providing several presentations to HWA staff on the importance of the consumer perspective, consumer views of workforce supply and training for the future, and surveys on consumers' ability to access healthcare.

The CHF Secretariat also provided policy support for consumer representatives on HWA's various project advisory committees. The most significant work undertaken during the contract period was advice provided on HWA's *Health Workforce 2025* agenda.

Facilitating consumer input to the PCEHR

CHF received funding from the National E-Health Transition Authority (NEHTA) to facilitate consumer input to the national eHealth record. The aim of this project is to support health consumers and other community members' engagement in the implementation of personally controlled electronic health records (PCEHR), and to keep them informed about the progress of the program.

Through this project, CHF aimed to:

- raise community awareness of the PCEHR system;
- contribute to the enhancement of the PCEHR system by assisting in the development of additional functionality which supports consumer expectations around information to be contained within individual PCEHRs;
- provide input from a consumer perspective on the national e-health strategy review; and
- develop strategies to enhance health outcomes through the implementation of this and other eHealth initiatives.

A key component of this project was communicating to health consumers and the community regarding the eHealth program.

REAL PEOPLE REAL DATA

Consumer narratives or stories can tell us a lot about patient and carer experiences of health, healthcare and health outcomes. However, due to their anecdotal nature, consumer narratives are often overlooked in evidence-based policy and decision making.

CHF has developed the *Real People, Real Data* tool to ensure that consumer knowledge and experience can make a robust contribution to evidence-based decision making.

The *Real People, Real Data* tool is based on a rigorous academic methodology that involves:

- Identification of key stages that people may experience as they navigate the health system;
- Semi-structured qualitative interviewing with individual health consumers about their experience of these stages in the context of their patient (or carer) journey;
- A two-step analysis process that involves:
  - Creation of an 'Patient Experience Wheel', which concisely presents key experiences in a person's narrative of their patient journey, and presents emotional high and low points in this journey as well as identifying critical points for policy or health service interventions; and
  - Identification of relevant indicators of consumer-centred care that shape the quality of experience that the Wheel presents.

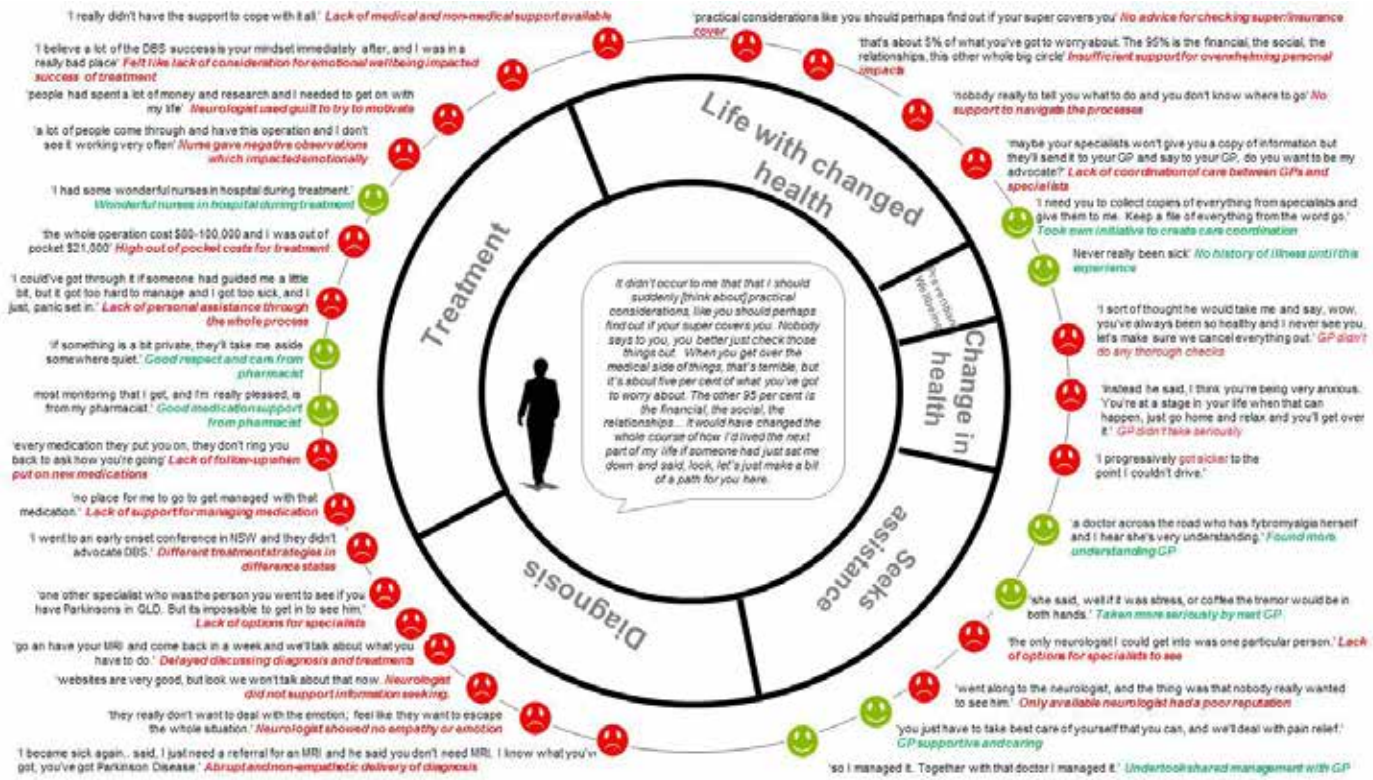
CHF has also produced a 'storytelling toolkit' for organisations that want to listen to, understand and act on consumer experience data. This includes guidance on:

- Using CHF's Patient Life Journey Framework, a flexible framework for understanding consumer health experiences and inviting consumer experience narratives;
- Planning, undertaking and analysing semi-structured interview data;
- Using the Patient Experience Wheel tool;
- Analysing consumer experience using indicators of consumer-centred care and good health outcomes.

CHF commissioned an independent evaluation of the *Real People, Real Data* tool, which was conducted by Dr Allison Tong from the University of Sydney's School of Population Health. The evaluation found that:

"The Real People, Real Data tool and process provides a robust, systematic, and transparent methodology for collecting, analysing and presenting consumer narrative to inform health decisions.

The RPRD tool-kit is detailed and comprehensive with easy-to-use templates and guides. The flexibility of the process ensures that that the toolkit can be adapted to meet the needs of an organisation...



The tool can be used to elicit rich, in-depth data on consumer perspectives, beliefs and values. The data provides critical insights into the profound and pervasive impact of health and healthcare experiences on the lives of individual consumers relevant to the health decision-making context. A major strength (or value-add) of the RPRD tool is the consumer story wheel. This story wheel for presenting the consumer narrative is the first of its kind in the world. The story wheel is innovative and effectively highlights critical health and healthcare issues and the key aspects of consumer experiences as identified by consumers themselves. It also allows consumer stories to be captured in a more coherent, chronological order.

Relevant data can be easily accessed and retrieved. Consumer control is maintained throughout the process in a respectful and explicit manner..."

Best of all, the *Real People, Real Data* tool is freely available to consumers and consumer organisations on the *OurHealth* website!

More information on this project is available under the Project section on page 8

MEDIA

The new Federal Government's 2014-15 Budget proposals to introduce a Medicare co-payment and increase PBS charges generated many media demands for CHF's views. Over the year CHF issued more than 25 formal media releases and articles on the issue of co-payments/out of pocket costs and Medicare changes as well as fielding dozens of requests for television, radio and newspaper interviews.

Throughout the year CHF maintained an active media profile, generating 1,454 media mentions, according to media monitor, Meltwater. Where feasible CHF sought to take a proactive stance in three national media campaigns it launched over the 12 months. Before the 2013 Federal election, CHF led two campaigns, the first, "Mend Medicare", which sought a rethink of the health system to end growing inequities, in the second, CHF led a coalition with ACOSS and CHOICE to support Federal Government plans for cheaper medicines through accelerated PBS price disclosure.

CHF co-sponsored with the National Press Club, the federal election health debate between then Health Minister, Tanya Plibersek, and then Shadow Health Minister, Peter Dutton.

After the September 2013 election, CHF mounted a further campaign to urge the new Federal Government to carry through on PBS price disclosure, pointing out the mounting cost of lost savings, estimated at $1 billion, if the measures were not implemented. This drew widespread media interest and it was later suggested that the pressure prompted by the CHF campaign in the face of a strident Pharmacy Guild of Australia campaign was decisive in influencing the new Federal Government to maintain the policy.

CHF also drew widespread media requests for response when the Federal Government announced above inflation health insurance premium increases just before Christmas..."unhappy Christmas tidings for many families," we said.

In March 2014, CHF released a report challenging the policy of healthcare co-payments which drew national media interest, prompting questions to the Health Minister, Peter Dutton. Minister Dutton also contributed to the April 2014 issue of *Health Voices* which published the views of experts on how to get better value for money out of health spending. In May 2014 CHF commissioned an Essential Media poll which found that most Australians opposed a co-payment and thought it would mean more people going to emergency departments. But the Budget announced $8.5 billion in cuts from healthcare "while slugging consumers with extra charges..." CHF declared. CEO Adam Stankevicius addressed the mass media conference at Federal Parliament on budget night and was interviewed by ABCTV News 24.

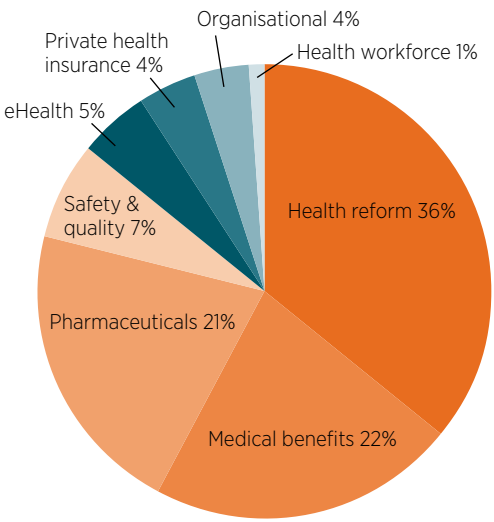
The Croakey website retained its strong interest in CHF's stance, reporting our comments and publishing our articles on subjects such as the value of Medicare Locals.

The CHF's advice in dealing with the media was also sought by the National Health and Medical Research Council which sought feedback on a proposed standard dealing with media interviews of hospital patients.

Among other topics CHF issued statements on were:

- Pharmacies' costs and regulation
- Chemotherapy costs
- eHealth
- Hospitals performance
- Private health insurance benefits
- Medical research and patient safety issues
- Anti-biotic resistance
- Dental costs
- Obesity
- Food labelling
- Pharmaceutical company benefits to doctors
- Statins

2013–14 media releases by topic



CAMPAIGNS

August 2013, just before the Federal Election, saw CHF taking a leading role in media campaigns with other national organisations on two key issues: out of pocket healthcare costs and later, separately, cheaper medicines.

Mend Medicare

Against a background of CHF's earlier campaigns highlighting rising out of pocket costs and evidence of an emerging two-tier health system, CHF joined an initiative designed to highlight health costs as an election issue, CHF joined Catholic Health Australia, the Australian Nursing and Midwifery Federation, the Public Health Association of Australia and Mental Health Australia to promote the *Mend Medicare* campaign. Health system experts, Professor Christine Bennett, who chaired the National Health and Hospitals Reform Commission, Dr Stephen Duckett, health analyst with the Grattan Institute and Dr Paul Gross, an international health systems consultant, made themselves available to provide media commentary on the issue.

The *Mend Medicare* report called on leaders to spell out their pre-election plans for Medicare and asserted that the growth in out of pocket costs was turning Medicare into a two-tiered system. *Mend Medicare* argued that Australia had outgrown its original system. Medicare had been designed to provide short-term episodic care rather than address the more chronic and complex illnesses we see today. The campaign drew interest from the media and other health groups. "It's time for political leaders to commit to a shakeup of Medicare and tell voters what they would do to stop the spread of a two-class health system," CHF CEO Carol Bennett told *The Age*.

Cheaper medicines

In the second big media initiative of August 2013, CHF launched with ACOSS and CHOICE a national campaign for cheaper medicines, revealing research showing Australians were still paying up to 10 times the prices charged in Britain, despite Government measures to bring down prices. The campaign was in response to a Pharmacy Guild petition seeking compensation from government for the impact of cheaper prices under the expanded and accelerated price disclosure arrangements. The CHF-led campaign included the Stand up for cheaper medicines website which enabled voters to alert election candidates to the need for cheaper medicines. A day after the launch, then Health Minister, Hon. Tanya Plibersek MP, announced further price disclosure measures which would yield savings of $1.8 billion.

CHF maintained the pressure on the cheaper drugs issue and a week after the 2013 Federal Election in September unveiled a fresh approach to highlight the estimated lost savings, amounting to more than $14 million in the first week of the new government. ***The campaign bore fruit. Despite intense pressure from the Pharmacy Guild of Australia, the new Health Minister, the Hon. Peter Dutton MP, announced in November 2013 that the Federal Government was pressing ahead with legislation to accelerate price disclosure and thus drug price cuts.***

Co-payments in Healthcare

In March 2014 CHF released a report it had commissioned into co-payments prepared by Jennifer Doggett (see separate item for more detail on report). New CEO, Adam Stankevicius, said the report showed co-payments would hit the chronically ill and that CHF wanted to ensure changes were evidence-based and would not hit those most in need. The report attracted widespread coverage from media including Fairfax newspapers, *The Australian*, the Melbourne *Herald Sun* and the ABC including *Radio National.*

In May 2014, a week before the federal budget, CHF was one of five health organisations which wrote to the Prime Minister expressing deep concerns about the recommendations of the National Commission of Audit, which proposed a $15 Medicare co-payment. Other signatories who publicly spoke out against the proposals were the Australian Health Care Reform Alliance, the Australian Health Promotion Association, the Foundation for Alcohol Research and Education and the Public Health Association of Australia.

After the Budget $7 co-payment announcement, CHF took several opportunities to question the proposal, including citing new data showing rising out of pockets costs. By 30 June 2014, there was little sign that the Federal Government would secure Senate support for legislation to implement its co-payment for GP, radiology and diagnostic imaging services.

WEBSITE AND PUBLICATIONS

In March 2014, CHF released a new report on co-payments in the health system. The report shows that introducing new co-payments will hit the chronically ill and people on low incomes the hardest and fail to generate cost savings for the health system. The analysis of research into co-payments commissioned by the CHF concludes new co-payments will simply result in decreased access to healthcare and will mean more people will delay treatments, with more financial hardship.

The analysis, by health researcher Jennifer Doggett, shows there is a significant body of international evidence that reveals co-payments create barriers to access to healthcare and create further financial disadvantage.

The *Empty Pockets: Why Co-payments are not the solution* report is available at https://www.chf.org.au/pdfs/chf/Empty-Pockets_Why-copayments-are-not-the-solution_Final-OOP-report.pdf

The *OurHealth* consumer website (www.ourhealth.org.au) was designed to facilitate consumer experience-sharing and provide a support resource for consumer advocates contributing to health decision-making at the local, jurisdictional and national level. The website continues to provide an online platform where consumers can share ideas, issues and healthcare experiences to support informed consumer advocacy and improvements in our health system. In the past year, 80 detailed stories have been added to the 'Consumer Stories' section. Consumer conversation in the 'Have a say' forum has continued to canvass a wide range of health system experience.

There is also a formal partnership in place between CHF and Patient Opinion through CHF's *Our Health* website, and the *Patient Opinion* website (www.patientopinion.org.au). The Patient Opinion website enables consumers to share their story of using a health service, which is published on the website and sent to the health service for a response. The partnership ensures that consumer experiences are directed to the most appropriate platform and audience.

CHF's Facebook account and Twitter commentary continue to provide members, stakeholders and the media with up-to-date information on CHF's work. They also provide the opportunity for consumers to directly engage with CHF's policy work.

CHF members continue to receive monthly updates on CHF's work and other major health sector news through our newsletter, *health*UPdate.

CHF also provides a bimonthly newsletter, *Consumers Shaping Health*, which shares information on our policy and advocacy work with politicians and other key stakeholders. *Consumers Shaping Health* is distributed in both electronic and hard copy formats.

CHF's website (www.chf.org.au) - The 'Latest news' section regularly updates our audience with the most recent information on CHF's work and other significant health policy updates.

Health Voices in its two editions for the year focused on issues dealing with central aspects of the developments in the health portfolio under the Coalition Government. In October last year the edition titled "Primary care at the turning point", explored the potential and challenges of primary care from the perspective of more than a dozen consumer advocates, experts and providers. The journal came out at the new Government was about to launch an inquiry into Medicare Locals which resulted in their planned abolition.

This year's April edition, "Better bang for your buck", brought together the opinions of 20 health leaders on the subject of spending, ranging from Health Minister, Peter Dutton, to health system analyst Professor Stephen Duckett. The aim was to respond to Mr Dutton's earlier call for a national debate on health spending by presenting expert views on what options there are for driving better value out of health expenditure. Strong words came from Mr Dutton who in his article asserted public hospitals were "shackled by archaic practices". Several writers posed solutions to make health more cost-effective rather than introducing a Medicare patient co-payment.

Health Voices is distributed to all MPs and Senators and to other national health organisations.

http://www.chf.org.au/health-voices.php

EMPTY POCKETS:

WHY CO-PAYMENTS ARE NOT THE SOLUTION

CHF released a new report about health co-payments in March 2014, in response to the call by the Health Minister, Peter Dutton, for a national conversation on making healthcare sustainable.

CHF argued that Australians already pay for a higher proportion of their health costs through co-payments than do people in other countries. The analysis CHF commissioned on co-payments shows even higher co-payments would be counter-productive, hitting the needy but failing to deliver an overall economic benefit.

The comprehensive analysis conducted by health researcher Jennifer Doggett found that:

- Co-payments will result in people delaying treatments, leading to higher health costs overall.
- There is no evidence to show there will be overall cost savings but there is a clear risk of compounding existing problems and further disadvantaging people.
- Co-payments will create more financial hardship, have a big impact on sick and poor people and compound existing disadvantage
- Introducing co-payments will result in decreased access to healthcare.
- The report says existing co-payments already cause financial hardship for many consumers - particularly people with chronic conditions and/or on low incomes.
- The report says there is a significant body of international evidence to show co-payments create barriers to access for healthcare for many consumers without decreasing overall health costs
- The report reveals a huge 17% of all total healthcare expenditure in Australia is now being funded by individual co-payments. It is now the largest non-government source of funding for health, goods and services and is significantly higher in Australia than most OECD countries.

CHF also conducted a survey, which provided consumers with an opportunity to share their experiences on the impact of out-of-pocket costs on their healthcare, beyond quantitative data and research.

The key findings of the survey are:

- Half of consumers have annual out-of-pocket costs in excess of $1,000, with consumers who are high users of healthcare experiencing even greater costs.
- Consumers who have private health insurance are likely to face much higher out-of-pocket costs than those who do not.
- Out-of-pocket costs result in a significant percentage of consumers delaying seeking medical assistance for fear of being unable to shoulder the burden of payment.
- Inability to receive medical care, or having to pay high out-of-pocket costs, dramatically impacts consumers in other aspects of life, to include added stress, restricted financial flexibility, and providing basic needs for families.

Although out-of-pocket costs matter in terms of dollars and cents, the impact on quality of care and life is where these inflationary costs of healthcare hurt the most.

"One day of a fortnight of my earnings goes to my medication alone. Just so I can work and live a life. I also have to have supplement drinks so I don't starve (gastroparesis) and I don't get any assistance with cost. It is difficult to manage a chronic illness (or more) in a medical setting that is based in acute medicine. It would be great to have support to work and be a functional member of society. Rather than having to struggle on alone in a system that doesn't support non-acute illnesses."

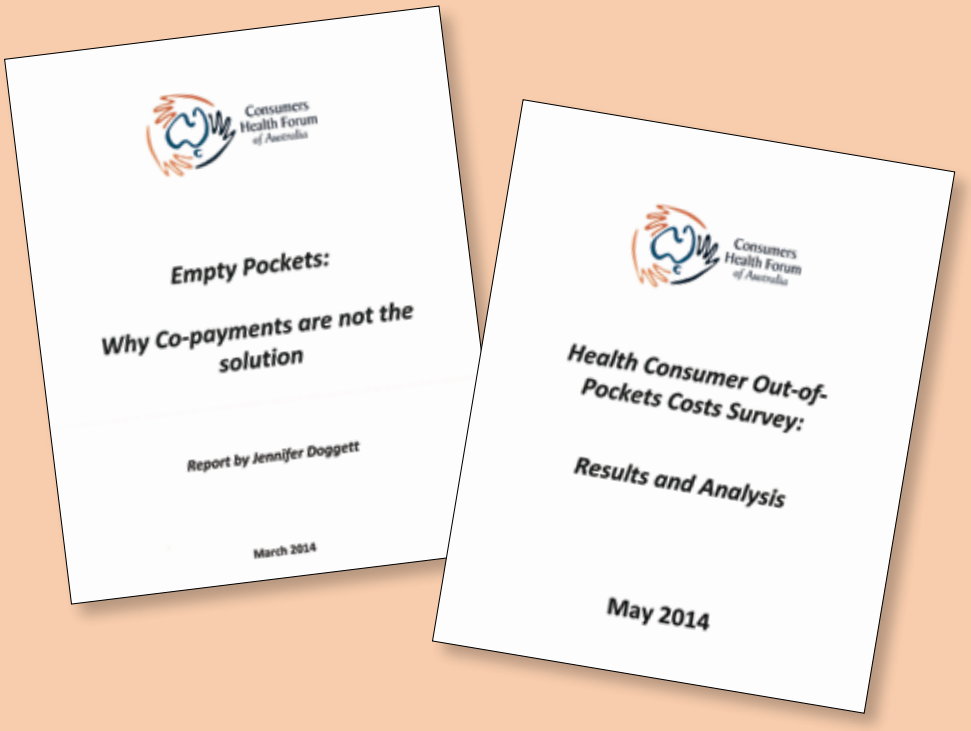
Consumer from VIC

"My GP practice does not bulk-bill and there is a big gap between what I pay for a visit and what is rebatable [sic] by Medicare. I have serious and on-going medical problems which need constant monitoring and the financial stress is causing mental health problems. My mentally ill adult son avoids GP contact because he is on a disability pension and cannot afford treatment."

Consumer from ACT

"We don't go to the doctor unless it's absolutely concerning. If it's me or my partner, we just use over the counter medication to avoid going all together; which means we don't always get the treatment we need."

Consumer from WA



MEMBERS & REPRESENTATIVES

CONSUMER REPRESENTATIVES

Consumer representatives bring an essential consumer perspective to decision-making committees. They ensure that the committees on which they serve focus on consumer experience and consumer health outcomes. This contributes to better decisions in planning, policies and programs that shape the health of Australians.

CHF supports consumer participation in health decision-making by nominating and supporting consumer representatives to nationally strategic committees. Just as important, CHF provides committee organisers and secretariats with information about best practice in consumer representation, and supports committees by advertising vacancies to the CHF network. CHF also makes available resources to support consumer representatives working at any level of the health system.

In 2013-14 CHF nominated and supported consumer representatives who contributed to a wide range of national health committees. Their contribution was sought and valued on a wide variety of Australian Government Department of Health and Ageing, industry, professional and research project committees dealing with national health issues. This year CHF nominated to 87 consumer representative positions on 82 committees. A full list of CHF-nominated consumer representatives and the strategic committees on which they served in 2013-14 is provided as an appendix to this Annual Report.

Throughout the year CHF continued to assist committee organisers and secretariats with advice about best practice support of consumer contribution to committees. Where appropriate support is in place (including in the form of travel costs and sitting fees), CHF advertised consumer representative opportunities to our network via the www.chf.org.au website and the monthly members e-bulletin *HeathUPdate*. CHF directly nominates to nationally strategic health committees but gladly advertises appropriately supported vacancies to our network so that the consumer representatives best placed to take on this work are aware of these opportunities.

The CHF website makes available valuable user-friendly resources designed for committee secretariats and Chairs. These resources assist committees to provide the administrative support, appropriate processes and leadership that allow effective consumer contribution. The *OurHealth* website developed through the *Our Health, Our Community* and *Real People, Real Data* projects, supports consumers to share ideas and experiences to improve the health system. Consumer representatives can draw on these conversations as well as online training and information resources designed specifically to support them in their work.

CHF thanks consumer representatives for their contributions in 2013–14.

MEMBERS

CHF's membership includes diverse consumer health organisations. Among these are organisations that operate nationally, at the state and territory level, and organisations that work for the interests of particular groups of health consumers at the regional and local levels. CHF's members include local self-help organisations that operate with very limited financial resources and large organisations with policy and service delivery portfolios supported by multi-million dollar budgets. Illness groups, disability organisations and specific populations groups including young people, older people and women are represented among CHF's members. Through the members of our members, it is estimated that CHF directly reaches and represents approximately two million Australian health consumers.

CHF's members are highly valued partners in the effort to make the consumer perspective a priority for decision-makers. CHF's membership includes Voting Members, Associate Organisational Members, Associate Corporate Members, Associate Individual Members and Honorary Life Members. A full list of CHF members in 2013-14 can be found as an appendix to this Annual Report.

CHF's Voting Members are organisations that represent consumer and community opinions (and do not primarily represent professional, provider or commercial interests); have membership open to consumers who can be elected to the board or governing body of the organisation; fully support the aims of CHF and have aims and opinions that significantly represent the opinions of consumers. Voting Members determine CHF's governance by exercising their voting rights to nominate and elect CHF Board members.

In 2013-14 CHF members received:

- An annual subscription to *healthUPdate*, CHF's monthly e-newsletter that provides up-to-date information about CHF activities and issues and opportunities of interest to members;
- An annual subscription to *Consumers Shaping Health*, CHF's newsletter published every two months, providing current information on CHF advocacy;
- An annual subscription to *Health Voices,* CHF's Journal, published twice a year, providing detailed analysis of the issues affecting health consumers;
- Access to the Members' Area of the CHF website which includes information about the work of CHF's consumer representatives.
- Policy briefings and consultation papers on key health issues, including Member Briefings on the Personally Controlled Electronic Health Record, Pre-Federal Budget Briefing, Post-Federal Budget Briefing, and the National Commission of Audit.
- Copies of new CHF reports and submissions based on health consumer views, including an advance release of CHF's Submission to the Senate Community Affairs Reference Committee's Inquiry into Out of Pocket Costs in Australian healthcare, both to inform members and to support members preparing their own submissions.

In 2013-14 many CHF members took the opportunity presented by the *OurHealth* website to highlight the issues affecting their constituencies. The library of discussions, posts, news articles and personal stories that bring to life the experience of health consumers involved in the CHF member network continues to grow.

CHF thanks our members for their involvement and support in 2013–14.

GOVERNANCE

CHF BOARD MEMBERS

At the 2013 AGM, 2 new members were elected to the CHF Board, for a term of 3 years. In February 2014 the Board announced changes to the leadership of the organisation. Mr Tony Lawson, former CHF Treasurer (and Chair, Health Consumers Alliance of South Australia), was elected as Chair of CHF, succeeding Ms Karen Carey who relinquished the position for health and business reasons.

The CHF board expressed regret at Ms Carey's departure and acknowledged that she had turned her own challenging health experiences to further the interests of health consumers everywhere. The Board also elected Ms Jo Watson as Chair of the Finance and Audit Committee.

Anthony (Tony) Lawson BA, BSoc. Admin, FIPAA, FAIM — Chair

Tony has been a member of the CHF board for four years and in that period has served as Chair Governance Committee and until appointment as Chair was Treasurer and Chair Finance and Audit Committee.

Tony has also represented CHF on various boards and committees including Health Workforce Australia, Australian Council on Healthcare Standards Member, Australian Atlas of Healthcare Variation Advisory Group - Australian Commission on Safety and Quality in Health Care and Chair, National Working Group on Performance Assessment - National Health Performance Authority.

Tony is also the current Chair of Health Consumers Alliance in South Australia and has facilitated the organisation's evolution into the peak consumer health organisation for South Australia. He has extensive experience in consumer participation and engagement projects, including as Commissioner for Consumer Affairs South Australia.

Ainslie Cahill, Deputy Chair

Ainslie has long been involved in health advocacy and has a special interest in positive ageing. She is currently the CEO of Arthritis Australia where she leads a range of advocacy campaigns for Australians living with arthritis, including Time to Move Arthritis, Ease of Use Packaging and Easy to Read Labelling. Ainslie has served on the CHF Governing Committee since 2008 and has chaired the CHF Governance Committee. She was a member of the Finance and Audit Committee and Chair of the CHF Constitution Subcommittee from 2008-2010.

John Daye

John has extensive experience in community advocacy and was awarded an Order of Australia Medal for his advocacy on behalf of the Victorian community. John has contributed to health and research oriented national and state committees, including positions on the Alfred Hospital HIV Advisory Care Committee and the Community Advisory Committee of Bayside Health

Stephen Murby

Stephen is committed to ensuring that Australia meets the public health challenge of both an ageing population and an increasing number of people living with multiple condition chronic illnesses. He is a member of the International Advisory Board of the Alliance for Safe Biologic Medicines (USA) and a Life Fellow of the Royal Society of Arts (UK). Prior to retirement in 2012 he spent six years as the CEO of Cystic Fibrosis Victoria and was also Chair of the Chronic Illness Alliance, Chair of CHF and a Board member of the Australian Council for Healthcare Standards during that time. Formerly the Vice President of Swinburne University of Technology, where he worked for nine years, he spent five years before that in Hong Kong as the Foundation Head of Continuing and Community Education at the now Open University of Hong Kong.

Moya Sandow, Chair— Governence Committee

Moya has extensive experience in health advocacy, with a focus on rural and remote health issues and the use of technology and telecommunications to progress such issues. For the past twenty years, Moya has held executive positions with both State and National non-profit organisations, including Health Consumers of Rural and Remote Australia, where she has worked alongside statutory authorities and government bodies to negotiate better health outcomes for consumers.

Karen Carey

Karen is a former Chairperson of the Health Consumers' Council of WA and has participated as a consumer representative on over eighteen committees and consumer working groups. Karen has been nominated by CHF to high level committees such as the Prostheses and Devices Committee and the National Health Priority Areas Council.

Robert Pask, Chair–Membership Committeed

Robert has been an active advocate for people with disabilities for more than 10 years. He is currently Community Engagement and Advocacy Manager at Safe Futures Foundation and is a member of a range of committees including the Chronic Illness Alliance Committee of Management and the Cairo Project for inclusive housing. In the past 12 months Robert was the recipient of the National Disability Award "Excellence in Advocacy & Rights" as well as Huntington's Victoria Advocacy Award.

Jo Watson

Jo is highly respected at the grass-roots and at the highest levels for her achievements over almost two decades in improving healthcare for Australians living with HIV/AIDS. Health literacy, research, quality use of medicines and support for self-management have been at the heart of her work and she is co-founder of the AIDS Treatment Project Australia. It is auspiced by the National Association of People Living with HIV/AIDS (NAPWA), an organisation that Jo has led from meagre beginnings to become a national peak and a lead partner in the Australian HIV response.

Jan Donovan

Jan Donovan is a consumer advocate who represents health consumers nationally and internationally. Her work in health policy and the national medicines policy on behalf of health consumers includes current appointments to the Drug Utilisation Sub Committee, the National Health Performance Authority- Primary Care Advisory Committee, the PASC and Medical Services Advisory Committees from 2011 to June 2014.

Jan served on the NPS Board as the consumer class director for three terms and the Australian Primary Health Care Research Institute Board at ANU for two terms.

She is committed to reducing health inequalities and supports health prevention, consumer centred care and equitable access to high quality medicines and health technologies. She is a member of the Chronic Illness Alliance and Health Issues Centre in Melbourne. She has a strong focus on people with chronic illness, particularly the need to support people who struggle with mental illness. She takes a strong interest in maternal and child health and the health and social issues affecting all marginalised people.

Christine Walker

Christine is the CEO of the Chronic Illness Alliance Inc., a peak body representing fifty consumer and advocacy organisations for people with chronic illness. The aim of the Alliance is to build a better focus in health policy and health services for all people with chronic illness.

Board Attendance 2013–2014

Name	Position	Term of Office	Board Meetings Attended	Sub Committee Meetings attended	Total Number of Meetings Attended
Ainslie Cahill	Board Deputy Chair	To October 2014	5	N/A	5
Karen Carey	Chair (to February 2014)	Resigned February 2014	2	1	3
John Daye	Board Member	To October 2015	4	N/A	4
Tony Lawson	Chair	To October 2016	5	4	9
Stephen Murby	Board Member	Took Leave of Absence from February 2014 to October 2014	0	N/A	0
Robert Pask	Board Member	To October 2015	4	N/A	4
Moya Sandow	Board Member — Chair Finance & Audit Sub Committee	To October 2016	5	3	8
Jo Watson	Board Member	To October 2015	5	5	10
Jan Donovan	Board Member	To October 2017	2	1	3
Christine Walker	Board Member	Resigned June 2014	1	N/A	1

STAFF

The Board of the Consumers Health Forum of Australia is supported by a dedicated team of secretariat staff who work day to day implementing the strategic vision for the organisation. In 2013–14, there were significant changes to the secretariat, with the departure of our long term CEO, as well as changes in the policy and consumer relationships teams.

Staff from 1 July 2013 — 30 June 2014

Chief Executive Officer

Carol Bennett	To November 2013
Rebecca Vassarotti	Acting to February 2014
Adam Stankevicius	From February 2014

Communications Director

Mark Metherell

Project and Communications Officer

Fiona Walls	(from September 2013)

Policy Manager/Director

Maiy Azize	To August 2013
Rebecca Vassarotti	To November 2013
Donna Stephenson	From March 2014

Policy Team

Dewi-Inala Zulkefli	Project and Policy Officer
Carter Moore	Policy Officer
Priyanka Rai	Policy and Communications Officer
Maiy Azize	Project Officer (to March 2014)
Carlo Malaca	Project and Communications Officer (to April 2014)

Consumer Relationships Manager

Deborah Smith	To April 2014
Sarah Spiller	From April 2014

Consumer Relationships Co-ordinator

Ghislaine Alventoza

Online Community Specialist

Laura Messom (to October 2013)

Operations Manager and Company Secretary

Kerry Hollis

Office Manager

Dianne Coghlan

Administration Officer

Sue Claydon

CONSUMER REPRESENTATIVES 2013–14

Consumer representatives make a valuable contribution to committees by ensuring that the consumer perspective is considered in health decision-making. They remind committees that health policy and healthcare delivery must focus on consumer experience and consumer health outcomes. They bring consumer issues and important social values to the table.

Australian Commission for Safety and Quality in Healthcare (ACSQHC)

Australian Atlas of Healthcare Variation Advisory Group
Tony Lawson (from June 2014)

Clinical Care Standards Advisory Committee
Moya Sandow

Primary Care Committee
Christine Walker
Michael Cousins

ACSQHC and the Independent Hospital Pricing Authority

Joint Working Party on Pricing for Safety and Quality in Health Care in Australian Public Hospitals
Cindy Schultz-Ferguson

Australian Council on Health Care Standards

Council and Board
Tony Lawson

Australian General Practice Accreditation/QIP Ltd

Board
Jo Watson

Australian Government Department of Health

Australian Community Pharmacy Authority
Melissa Cadzow

Chief Medical Officer's Clinical Advisory Committee
Karen Carey (to December 2013)

Codes of Conduct Advisory Committee
Anne McKenzie

Diabetes Program Advisory Group
Carol Bennett (to November 2013)
Adam Stankevicius (from April 2014)

Expert Advisory Group for Post-market Review of Products Used for the Treatment of Diabetes
Helen Edwards

Expert Advisory Group for the Post-Market Review of Pharmaceutical Benefits Scheme Medicines Used to Treat Asthma in Children
Debra Kay (from May 2013)

Fifth Community Pharmacy Agreement Reference Group
Kate Moore

Health Technology Assessment Consultative Committee
Karen Carey

Improving the Safety and Quality of Diagnostic Imaging in Australia
Geraldine Robertson (from October 2013)

Medical Services Advisory Committee (MSAC)
Jan Donovan
Russell McGowan

MSAC Evaluation Sub-committee
John Stubbs
Debra Kay (joined May 2014)

MSAC Protocol Advisory Sub-committee
Anne McKenzie
Eileen Jerga

National Immunisation Committee
Alison Marcus

National Oral Health Promotion Plan Committee
Jan Donovan

Natural Therapy Review Advisory Committee
Alison Marcus
Ken Harvey

PCEHR Advanced Care Consultation Group
Maiy Azize (from September 2013)

Pharmaceutical Benefits Advisory Committee
Jo Watson

Pharmaceutical Benefits Pricing Authority
Karen Carey (to December 2013)

Prostheses Listing Advisory Committee
Janey Wale

Prostheses Clinical Advisory Group – Cardiac
Eileen Jerga

Prostheses Clinical Advisory Group – Ophthalmic
Karen Carey

Prostheses Clinical Advisory Group – Specialist Orthopaedic
Janey Wale

Prostheses Clinical Advisory Group – Vascular
Eileen Jerga

Quality Use of Pathology Committee
Valerie Hanrahan
Mary Potter

Reference Group for the Post-Market Review of the Life Savings Drugs Program
Karen Carey (to December 2013)
Jo Watson (from 2014)

Safety and Quality Sustainability Forum
Carol Bennett (to November 2013)
Karen Carey (from November 2013)
Tony Lawson (from March 2014)
Adam Stankevicius (from March 2014)

Therapeutic Goods Administration Committees
Advisory Committee on Complementary Medicines (ACCM)
Patricia Greenway

Advisory Committee on Safety of Medicines (ACSOM)
Alison Marcus

Advisory Committee on Medical Devices (ACMD)
Janey Wale

Advisory Committee on Prescription Medicines (ACPM)
Janne Graham AM (to December 2013)
Katherine Briant

Advisory Committee on Medicines Scheduling
John Daye

Advisory Committee on Safety of Medical Devices
Karen Carey

Advisory Committee on Biologicals
Sharon Caris

Labelling and Packaging Review External Reference Group
Anne McKenzie

Medical Devices Reform Reference Group
Karen Carey

Therapeutic Industry Consultative Committee (TICC)
Carol Bennett (to November 2014)
Tony Lawson (from April 2014)

Therapeutic Goods Committee
Diane Walsh

Therapeutic Goods Advertising Code Council
Patricia Greenway

Complaints Resolution Panel
Shaun Hoyt
Geraldine Robertson and Rachel Bishop (alternates)

Working Group examining the regulatory requirements for complementary medicines
Carol Bennett (to November 2013)
Alison Marcus

Australian Government Department of Industry

Clinical Trials Advisory Committee
Ainslie Cahill (from April 2014)

Australian Health Informatics Education Council

AHIEC Working Committee
Chris Dickson

Australian Medical Council

Council
Diane Walsh (to November 2013)
Cindy Schultz-Ferguson (from November 2013)

Australian Medicare Local Alliance

Clinical Engagement and Cross Sector Collaboration – Project Advisory Committee
Elizabeth Carrigan (from August 2013)

Health Workforce Australia

Allied Health Workforce – Rural and Remote Generalists Project Advisory Group
Nicky Barry (from September 2013)

Standing Advisory Committee for the NGO Private Sector
Tony Lawson (to Febuary 2014)
Debra Kay (from February 2014)

Independent Hospital Pricing Authority
Evaluation of National Implementation of Activity Based Funding
Adam Stankevicius (from June 2014)

Stakeholder Reference Group
Stephen Murby (to October 2013)
Simon Towler (consumer advisor) (from October 2013)
Rebecca Vassarrotti (observer attendee) (from October 2013)
Donna Stephenson (observer attendee) (from March 2014)

International Association of Patients' Organizations (IAPO)

Board
Carol Bennett

Medicare Australia

Stakeholder Reference Group
Diane Walsh

Medicines Australia

Code of Conduct Committee
Anne McKenzie

Transparency Working Group
Alison Marcus

Code of Conduct Review Panel
Ken Harvey

Medical Technology Association of Australia

Code of Conduct Strategic Advisory Committee
Patricia Greenway

Medical Technology Industry Code of Practice External Review
Henry Ko (from June 2014)

Monash University

Breast Device Registry
Cindy Schultz-Ferguson (from December 2013)

National Health and Medical Research Council (NHMRC)

Expert Advisory Group Developing Ethical Guidelines For Eligibility Criteria And Allocation Protocols For Organ Transplantation From Deceased Donors
Diana Aspinall

Flouride Reference Groups
Debra Petrys (from April 2014)

National Health Performance Authority

Advisory Committee for the Second Report on Childhood Immunisation
Debra Petrys (from December 2013)

Child and Maternal Health Advisory Committee
Jan Donovan (from June 2014)

Cost per Weighted Separation Advisory Committee
Christine Gunson (from February 2014)

Health Care Efficiency Advisory Committee
Christine Gunson (from May 2013)

Hospital Mortality Report Advisory Committee
Mark Metherell (from February 2014)
Jan Donovan (from February 2014)

Primary Healthcare Advisory Committee
Jan Donovan

Performance Assessment Working Group
Tony Lawson (from September 2013)

National Prescribing Service
Australian Prescriber Advisory Editorial Panel
Adam Stankevicius (from April 2014)

Consumer Advisory Group
Ann McKenzie (from February 2014)
Paula Murray (from February 2014)
Rachel Bishop (from February 2014)
Leena Sudano (from February 2014)
Rigoula Roussakis (from February 2014)
Carlo Malacca (from February 2014)

Consumer Director
Debra Kay
Christine Walker (from May 2014)

Diagnostics Expert Advisory Panel (DEAP)
Richard Vines (from February 2014)

MedicineInsight Advisory Group
Mary Potter (from February 2014)
Judith Maher (from February 2014)
Leena Sudano (From February 2014)

Prescribing Intervention Advisory Group
Debra Petrys (from February 2014)

RADAR Editorial Group
Alison Marcus (from February 2014)

Strategic Evaluation Advisory Group
Joy Pettingell (from February 2014)
Shelley McInnis (from February 2014)

Painaustralia

Board
Diana Aspinall

Pharmacy Guild of Australia

HMR Research Project Advisory Group
Alison Marcus

Society of Hospital Pharmacists

Accredited Pharmacist Reference Group
Rebecca Vassarotti (from November 2013)
Moya Sandow (from May 2014)

MEMBERS 2013–14

CHF membership includes a wide variety of consumer organisations with an interest in health, including illness groups, disability groups and specific population groups such as youth, older people and women.

Voting Members

ACCESS Australia
Alzheimer's Australia Inc
Arthritis and Osteoporosis New South Wales
Arthritis and Osteoporosis Victoria
Arthritis Australia
Association for the Wellbeing of Children in Healthcare (AWCH)
Association of Genetic Support of Australasia Inc. (AGSA)
Association of Independent Retirees - NSW Division
Asthma Australia
Australian Council of Social Service (ACOSS)
Australian Federation of AIDS Organisations
Australian Pain Management Association Inc
Australian Pituitary Foundation Ltd
Australian Primary Care Community Partnership Incorporated
Blue Mountains GP Network Consumer Reference Group
Brain Tumour Alliance Australia
Breast Cancer Network Australia
Cancer Voices NSW
Cancer Voices SA
Carers Australia
Child Health Association Inc
Chronic Illness Alliance Inc
CJD Support Group Network Pty Ltd
Continence Foundation of Australia Ltd
Cystic Fibrosis Australia Inc
DES Action NSW
Diabetes Australia National
Diabetes NSW
Fabry Support Group Australia Inc (FSGA)
Federation of Ethnic Communities Council of Australia
Genetic and Rare Disease Network (GaRDN)
Genetic Support Network of Victoria
Haemochromatosis Australia
Haemophilia Foundation Australia
Health Care Consumers' Association of the ACT
Health Consumers Alliance of South Australia Inc
Health Consumers' Council (WA) Inc
Health Consumers NSW
Health Consumers of Rural and Remote Australia Inc
Health Consumers Queensland (HCQ)
Health Issues Centre Inc
Health Rights and Community Action Inc
Hepatitis Australia
Leukaemia Foundation of Australia
Limbs 4 Life
Lung Foundation Australia
Lynch Syndrome Australia
ME/CFS/FM Support Association Qld Inc
Meniere's Australia Inc
Multiple Sclerosis Australia (MSA)
National Association of People Living With HIV/AIDS Australia (NAPWHA)
National Seniors Australia Limited
National Stroke Foundation
National Support Groups Committee (Prostate Cancer Foundation of Australia)
Nepean Division of General Practice CRG
Northern Territory Medicare Local Ltd
Palliative Care Australia
Parkinson's Australia Inc
Polio NSW Inc

Queensland Alliance for Mental Health
Queensland Voice for Mental Health Inc
Rare Voices Australia Ltd
SHOUT (Self Help Organisations United Together)
Sleep Apnoea Association (ACT) Inc
Stroke Association of ACT
Sydney Children's Hospital Parent & Consumer Council
Tasmanians with Disabilities Inc
The Australasian Tuberous Sclerosis Society Inc
The Family Advisory Council at The Children's Hospital at Westmead
Women's Centre for Health Matters Inc

Honorary Life Members

Honorary Life Membership is awarded to an individual in recognition of sustained and significant contribution to CHF. To date, four Honorary Life Memberships have been awarded:
Ms Hilda Bastian
Ms Janne Graham AM
Dr Christopher Newell AM (deceased)
Ms Sheila Rimmer AM (deceased)

Associate Organisational Members

2013-14 Org Members
1st Available Pty Ltd
ACT Health
ASERNIP-S
Australasian Integrative Medicine Association Inc
Australian Dental Industry Association (ADIA)
Australian Diagnostic Imaging Association
Australian General Practice Accreditation Ltd (AGPAL)
Australian Healthcare and Hospitals Association
Australian Injecting & Illicit Drug Users League (AIVL)
Australian Nursing and Midwifery Accreditation Council (ANMAC)
Australian Nursing and Midwifery Federation (Victorian Branch)
Australian Physiotherapy Association
Australian Pompe's Association Inc
Australian Self Medication Industry Inc (ASMI)
beyondblue:
Bowel Cancer Australia
Canberra and Queanbeyan Attention Deficit Disorder Support Group Inc
Cancer Council South Australia
Cancer Council WA
Cancer Voices Australia
Cochrane Consumer Network (CCNet)
Community Engagement Unit School of Medicine
University of Western Sydney
Consumer Advisory Committee Health Quality and Complaints Commission
Department of Health (Victoria)
Epilepsy Australia
Gold Coast Medicare Local
Health Consumers Action Group WA Inc
Health Consumers Network
Heart Foundation
Inner South Community Health Service
Inner West Sydney Medicare Local Ltd
Lower Murray Medicare Local
Medicines Australia
Mental Health Community Coalition ACT
Multiple Sclerosis Limited
National Asthma Council Australia
National SIDS Council of Australia
Nepean Blue Mountains Medicare Local
Northern Sydney Medicare Local
NSW Therapeutic Advisory Group Inc
painaustralia Limited
Pharmaceutical Society of Australia
Pharmacy Guild of Australia (National Secretariat)
Queensland Bioethics Centre
Rare Cancers Australia Ltd
Royal Children's Hospital Melbourne Family Advisory Council
Thalassaemia Australia Inc
The Alcohol Tobacco and Other Drug Association ACT (ATODA)
The Society of Hospital Pharmacists of Australia (SHPA)
The Thalassaemia Society of NSW
Wide Bay Medicare Local
Women with Disabilities Australia (WWDA)

Associate Corporate Members

GlaxoSmithKline
Janssen-Cilag Pty Ltd
Merck Sharp & Dohme (Australia) Pty Limited
Pfizer Australia
ROCHE Products Pty Ltd

Associate Individual Members

91 individual members

FINANCIAL REPORTS

FOR THE YEAR ENDING 30 JUNE 2014

Consumers Health Forum of Australia Ltd

ABN 82 146 988 927

Contents

For the Year Ended 30 June 2014

Financial Statements

Consumers Health Forum of Australia Ltd

ABN 82 146 988 927

Directors' Report
For the Year Ended 30 June 2014

Your directors present their report on the Company for the financial year ended 30 June 2014.

1. General information

Directors

The names of each person who has been a director during the year and to the date of this report are:

Names	Position	Appointed/Resigned
Tony Lawson	Director, Chair	
Ainslie Cahill	Director, Deputy Chair	
Jo Watson	Director	
John Daye	Director	
Moya Sandow	Director	
Robert Pask	Director	
Jan Donovan	Director	Appointed: 28/2/2014
Christine Walker	Director	Appointed: 26/2/2014, Resigned: 4/7/2014
Karen Carey	Director	Appointed: 31/10/2013, Resigned: 19/1/2014
Stephen Murby	Director	Leave of absence: 28/2/2014
Carol Bennett	Executive Director	Resigned: 22/11/2013

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 Consumers Health Forum of Australia Ltd during the financial year were to provide information, representation and advocacy on national health issues for its membership of health consumer organisations. No significant changes in the nature of the Company's activities occurred during the financial year.

Objectives

The Company's continuing objectives are to advocate for appropriate and equitable health care for consumers, to provide a strong national voice for health consumers and raise health literacy of consumers, health professionals and stakeholders. We will know we have been successful when consumers are considered to be partners in their own healthcare and consumers have the ability to access, understand, evaluate and communicate information about their health and are active participants in all health arenas.

Strategy for achieving the objectives

To achieve these objectives, the Company will continue to proactively engage with members and all key stakeholders to encourage consumer representatives and members to report on key emerging issues for health consumers. We will facilitate forums for sharing and disseminating research undertaken by or auspiced by CHF and contribute to government initiated research and policy processes affecting key health consumer issues.

Members guarantee

The Company is incorporated under the *Corporations Act 2001* and is a company limited by guarantee. If the Company is wound up, the constitution states that each member is required to contribute a maximum of $ 1 each towards meeting any outstanding obligations of the Company. At 30 June 2014 the total amount that members of the Company are liable to contribute if the Company is wound up is $ 222 (2013: $ 198).

Consumers Health Forum of Australia Ltd

ABN 82 146 988 927

Directors' Report

For the Year Ended 30 June 2014

Information on directors

Tony Lawson

Experience

Tony has been a member of the CHF board for four years and in that period has served as Chair Governance Committee and until appointment as Chair was Treasurer and Chair Finance and Audit Committee. Tony has also represented CHF on various boards and committees including Health Workforce Australia, Australian Council on Healthcare Standards and the National Health Performance Authority. Tony is also the current Chair of Health Consumers Alliance in South Australia and has facilitated the organisation's evolution into the peak consumer health organisation for South Australia. He has extensive experience in consumer participation and engagement projects, including as Commissioner for Consumer Affairs South Australia. Tony is a member of the Central Adelaide Local Health Network Governing Council and the SA Health Ethics Health Advisory Council. Through his consulting practice Tony has undertaken many health related projects, a number of which focus on consumer engagement and satisfaction. Tony has supported various joint submissions led by CHF and collaborated with CHF through his roles at the Health Consumers Alliance.

Ainslie Cahill

Experience

Ainslie has long been involved in health advocacy and has a special interest in aged care. She is currently the CEO of Arthritis Australia where she has led a range of advocacy campaigns for Australians living with arthritis, including Removal of Joint Injections from the MBS and ease of use packaging and labelling. Ainslie has served on the CHF Governing Committee since 2008 and chairs the CHF Governance Subcommittee. She was a member of the Finance and Audit Committee and Chair of the CHF Constitution Subcommittee from 2008-2010.

Jo Watson

Experience

Jo is highly respected at the grass-roots and at the highest levels for her achievements over almost two decades in improving healthcare for Australians living with HIV/AIDS. Health literacy, research, quality use of medicines and support for self-management have been at the heart of her work and she is cofounder of the AIDS Treatment Project Australia. It is auspiced by the National Association of People Living with HIV/AIDS (NAPWA), an organisation that Jo has led from meager beginnings to become a national peak and a lead partner in the Australian HIV response. Jo is currently the Chair of the CHF Finance and Audit Sub-Committee.

John Daye

Experience

John has extensive experience in community advocacy and was awarded an Order of Australia Medal for his advocacy on behalf of the Victorian community. John has contributed to health and research oriented national and state committees, including positions on the Alfred Hospital HIV Advisory Care Committee and the Community Advisory Committee of Bayside Health. John has also been an active CHF member, serving on the Governing Committee since 2008 and undertaking varied consumer representative positions.

Information on directors (continued)

Moya Sandow

Experience

Moya has extensive experience in health advocacy, with a focus on rural and remote health issues and the use of technology and telecommunications to progress such issues. For the past fifteen years, Moya has held executive positions with both State and National non-profit organisations, including Health Consumers of Rural and Remote Australia, where she has worked alongside statutory authorities and government bodies to negotiate better health outcomes for consumers. Moya has served on the CHF Governing Committee since 2008.

Robert Pask

Experience

Appointed to the CHF Board in April 2012, Robert has been an active advocate for people with disabilities for more than 10 years. He is currently Multiple Sclerosis Australia's National Advocate Coordinator and is a member of a range of committees including the Victorian Disability Advisory Committee that advises the Victorian Community Services Minister; the Chronic Illness Alliance Committee of Management; The Disability Discrimination Legal Services Committee of Management. Robert has also been a member of other consumer committees including the Victorian Council of Social Services (VCOSS), the Victorian Electoral Commission Access Advisory Group, the Victorian Aids & Equipment Alliance, the Victorian Medical Advisory Committee & People with MS Committee. Robert has also worked with and supported the efforts of the Young People in Nursing Homes Alliance. As a graduate of Leadership Plus's inaugural leadership program for individuals with disabilities (2005, Robert is an active member of their Leaders Network). Robert retains a strong commitment to improving the health opportunities Australians with disability access.

Jan Donovan

Experience

Jan Donovan is a consumer advocate who for two decades has represented health consumers nationally and internationally. She is a member of the Chronic Illness Alliance in Melbourne. She has a particular interest in those with chronic illness including mental health, maternal and child health and the health and social issues affecting marginalised people. Jan has had the privilege of serving on the (NPS) Board as the consumer class director for nine years. She has also served on (APHCRI) board at ANU. She has been a deputy chair, director and company secretary of the Alola Australia Board - an organisation that supports the women and children of Timor-Leste. Jan has a BA from UWA and qualifications in education and a diploma in English as a second language from the University of Papua New Guinea. She has been a secondary teacher, most recently in Timor-Leste with the Dili International School as their English as Second language coordinator for 18 months. She also has a postgraduate diploma in public policy from the University of Melbourne. Her work experience includes time with the Council on the Ageing Australia as their National Policy Officer.

Consumers Health Forum of Australia Ltd

ABN 82 146 988 927

Directors' Report

For the Year Ended 30 June 2014

Information on directors (continued)

Christine Walker

Experience

Christine Walker is the Executive Officer of the Chronic Illness Alliance. This is an organisation which represents some fifty advocacy and consumer health groups comprising people with chronic illness. Its aim is to provide a better focus for people with chronic illness in areas of health policy, health funding and services, through education and information to the wider community, and to health professionals and policymakers.

Karen Carey

Experience

Karen is a former Chairperson of the Health Consumers' Council of WA and has participated as a consumer representative on over eighteen committees and consumer working groups. Karen has been nominated by CHF to high level committees such as the Prostheses and Devices Committee and the National Health Priority Areas Council. She has contributed to CHF policy work and is also the Chair of the CHF MBS Quality Framework Project Reference Group.

Stephen Murby

Experience

Stephen was first elected to the CHF Governing Committee in 2008 and served as Treasurer and Chair of the Finance and Audit Committee prior to accepting the role of A/Chair in 2011. During his time with CHF, Stephen has made pivotal contributions to the restructuring of the CHF business model and the finance and accounting systems. He also Chairs the Chronic Illness Alliance and is Chief Executive Office of Cystic Fibrosis Victoria. Stephen is committed to ensuring that Australia meets the public health challenge of both an ageing population and an increasing number of people living with multiple condition chronic illnesses.

Carol Bennett

Experience

Carol Bennett has worked at the executive level in health organisations for more than 15 years, including as CEO of peak national and state health bodies, and major consultancy roles with organisations including beyondblue. She is involved in a number of key national and international bodies including as a Council Member of the National Health and Medical Research Council and the Council on Strategy and Innovation in Human Services, and a Board Director of the International Alliance of Patients Organisations.

Consumers Health Forum of Australia Ltd

ABN 82 146 988 927

Directors' Report

For the Year Ended 30 June 2014

Meetings of directors

During the financial year, 5 meetings of directors were held. Attendances by each director during the year were as follows:

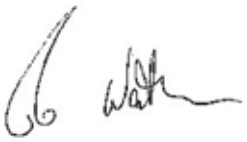
	Directors' Meetings	
	Number eligible to attend	Number attended
Tony Lawson	5	5
Ainslie Cahill	5	5
Jo Watson	5	5
John Daye	5	4
Moya Sandow	5	5
Robert Pask	5	4
Jan Donovan	2	2
Christine Walker	2	1
Karen Carey	2	2
Stephen Murby	3	-
Carol Bennett	2	2

Auditor's independence declaration

The auditor's independence declaration for the year ended 30 June 2014 has been received and can be found on page 6 of the financial report.

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

Director: .....
Tony Lawson



Director: .....
Jo Watson

Dated: 17 October 2014

Hardwickes
more than accounting

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Hardwickes
ABN 35 973 938 183

Hardwickes Partners Pty Ltd
ABN 21 008 401 536

Liability limited by a scheme approved under Professional Standards Legislation

Auditors Independence Declaration under Section 307C of the Corporations Act 2001

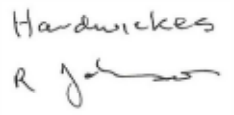
To the Directors of Consumers Health Forum of Australia Ltd

I declare that, to the best of my knowledge and belief, during the year ended 30 June 2014, there have been:

(i) no contraventions of the auditor independence requirements as set out in the *Corporations Act 2001* in relation to the audit; and

(ii) no contraventions of any applicable code of professional conduct in relation to the audit.

Hardwickes
Chartered Accountants



Robert Johnson FCA
Partner

Dated: 17 October 2014

Canberra

Consumers Health Forum of Australia Ltd

ABN 82 146 988 927

Statement of Profit or Loss and Other Comprehensive Income
For the Year Ended 30 June 2014

	Note	2014 $	2013 $
Revenue	9	**3,088,938**	3,646,678
Administrative expenses	10	**(1,162,130)**	(907,739)
Employee benefits expenses		**(1,376,617)**	(1,318,486)
Depreciation expense		**(12,228)**	(10,074)
Profit before income tax		**537,963**	1,410,379
Income tax expense		**-**	-
Profit for the year		**537,963**	1,410,379
Total comprehensive income for the year		**537,963**	1,410,379

Consumers Health Forum of Australia Ltd

ABN 82 146 988 927

Statement of Financial Position

As At 30 June 2014

	Note	2014 $	2013 $
ASSETS			
CURRENT ASSETS			
Cash and cash equivalents	2	**1,015,846**	1,902,017
Trade and other receivables	3	**241,314**	601,928
Other financial assets	4	**1,526,045**	26,045
Other assets	5	**23,943**	16,892
TOTAL CURRENT ASSETS		**2,807,148**	2,546,882
NON-CURRENT ASSETS			
Property, plant and equipment	6	**33,648**	24,474
TOTAL NON-CURRENT ASSETS		**33,648**	24,474
TOTAL ASSETS		**2,840,796**	2,571,356
LIABILITIES			
CURRENT LIABILITIES			
Trade and other payables	7	**493,573**	737,135
Short-term provisions	8	**45,636**	67,354
TOTAL CURRENT LIABILITIES		**539,209**	804,489
NON-CURRENT LIABILITIES			
Long-term provisions	8	**5,662**	8,905
TOTAL NON-CURRENT LIABILITIES		**5,662**	8,905
TOTAL LIABILITIES		**544,871**	813,394
NET ASSETS		**2,295,925**	1,757,962
EQUITY			
Retained earnings		**2,295,925**	1,757,962
TOTAL EQUITY		**2,295,925**	1,757,962

Consumers Health Forum of Australia Ltd

ABN 82 146 988 927

Statement of Changes in Equity
For the Year Ended 30 June 2014

2014

	Note	Retained Earnings $	Total $
Balance at 1 July 2013		**1,757,962**	**1,757,962**
Profit attributable to members of the entity		**537,963**	**537,963**
Balance at 30 June 2014		**2,295,925**	**2,295,925**

2013

	Note	Retained Earnings $	Total $
Balance at 1 July 2012		347,583	347,583
Profit attributable to members of the entity		1,410,379	1,410,379
Balance at 30 June 2013		1,757,962	1,757,962

Consumers Health Forum of Australia Ltd

ABN 82 146 988 927

Statement of Cash Flows

For the Year Ended 30 June 2014

	Note	2014 $	2013 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipts from customers		**3,497,606**	3,467,019
Payments to suppliers and employees		**(2,920,822)**	(2,397,876)
Interest received		**58,447**	33,446
Net cash provided by (used in) operating activities	12(b)	**635,231**	1,102,589
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of property, plant and equipment		**(21,402)**	(12,400)
Payment for held-to-maturity investments		**(1,500,000)**	-
Net cash used in investing activities		**(1,521,402)**	(12,400)
Net increase (decrease) in cash held		**(886,171)**	1,090,189
Cash and cash equivalents at beginning of financial year		**1,902,017**	811,828
Cash and cash equivalents at end of financial year	12(a)	**1,015,846**	1,902,017

Consumers Health Forum of Australia Ltd

ABN 82 146 988 927

Notes to the Financial Statements
For the Year Ended 30 June 2014

The financial statements cover Consumers Health Forum of Australia Ltd as an individual entity, incorporated and domiciled in Australia. Consumers Health Forum of Australia Ltd is a not-for-profit Company limited by guarantee.

The financial statements were authorised for issue on 17 October 2014 by the directors of the Company.

1 Summary of Significant Accounting Policies

(a) Basis of Preparation

These general purpose financial statements have been prepared in accordance with the *Corporations Act 2001* and Australian Accounting Standards and Interpretations of the Australian Accounting Standards Board. The Company is a not-for-profit entity for financial reporting purposes under Australian Accounting Standards. Material accounting policies adopted in the preparation of these financial statements are presented below and have been consistently applied unless stated otherwise.

The financial statements, except for the cash flow information, 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. The amounts presented in the financial statements have been rounded to the nearest dollar.

(b) 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, and bank overdrafts. Bank overdrafts are shown within short-term borrowings in current liabilities on the statement of financial position.

(c) Trade and other receivables

Trade and other receivables include amounts due from customers for goods sold and services performed in the ordinary course of business. Receivables expected to be collected within 12 months of the end of the reporting period are classified as current assets. All other receivables are classified as non-current assets.

Trade and other receivables are initially recognised at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment. Refer to Note 1(k) for further discussion on the determination of impairment losses.

(d) 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 and are therefore carried at cost less accumulated depreciation and any accumulated impairment losses.

In the event the carrying amount of plant and equipment is greater than the estimated recoverable amount, the carrying amount is written down immediately to the estimated recoverable amount and impairment losses are recognised either in profit or loss or as a revaluation decrease if the impairment losses relate to a revalued asset. A formal assessment of recoverable amount is made when impairment indicators are present (refer to Note 1(e) for details of impairment).

Subsequent costs are included in the asset's carrying amount or recognised as a separate asset, as appropriate, only when it is probable that future economic benefits associated with the item will flow to the

1 Summary of Significant Accounting Policies (continued)

(d) Property, Plant and Equipment (continued)

Plant and equipment (continued)
Company and the cost of the item can be measured reliably. All other repairs and maintenance are recognised as expenses in profit or loss during the financial period in which they are incurred.

Depreciation

The depreciable amount of all fixed assets is depreciated on a straight-line basis over the asset's useful life to the Company commencing from the time the asset is available for use.

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

Fixed asset class	Depreciation rates
Office equipment	20-33%
Member/Contact database	20%
Leasehold improvements	33%

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

Gains and losses on disposals are determined by comparing proceeds with the carrying amount. These gains or losses are recognised in profit or loss in the period in which they arise.

(e) Impairment of assets

At the end of each reporting period the Company assesses whether there is any indication that an asset may be impaired. The assessment will include the consideration of external and internal sources of information. If such an indication exists, an impairment test is carried out on the asset by comparing the recoverable amount of the asset, being the higher of the asset's fair value less costs to sell and value in use, to the asset's carrying amount. Any excess of the asset's carrying amount over its recoverable amount is recognised immediately in profit or loss.

Where the future economic benefits of the asset are not primarily dependent upon the asset's ability to generate net cash inflows and when the Company would, if deprived of the asset, replace its remaining future economic benefits, value in use is determined as the depreciated replacement cost of an asset.

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

(f) 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 Company 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.

(g) Provisions

Provisions are recognised when the Company 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.

1 Summary of Significant Accounting Policies (continued)

(h) Employee Provisions

Short-term employee provisions

Provision is made for the Company's obligation for short-term employee benefits. Short-term employee benefits are benefits (other than termination benefits) that are expected to be settled wholly before 12 months after the end of the annual reporting period in which the employees render the related service, including wages and salaries. Short-term employee benefits are measured at the (undiscounted) amounts expected to be paid when the obligation is settled.

Other long-term employee provisions

Provision is made for employees' long service leave and annual leave entitlements not expected to be settled wholly within 12 months after the end of the annual reporting period in which the employees render the related service. Other long-term employee benefits are measured at the present value of the expected future payments to be made to employees. Expected future payments incorporate anticipated future wage and salary levels, durations of service and employee departures, and are discounted at rates determined by reference to market yields at the end of the reporting period on government bonds that have maturity dates that approximate the terms of the obligations. Upon the remeasurement of obligations for other long-term employee benefits, the net change in the obligation is recognised in profit or loss as a part of employee benefits expense.

The Company's obligations for long-term employee benefits are presented as non-current employee provisions in its statement of financial position, except where the Company does not have an unconditional right to defer settlement for at least 12 months after the end of the reporting period, in which case the obligations are presented as current provisions.

(i) Leases

Leases of fixed assets where substantially all the risks and benefits incidental to the ownership of the asset, but not the legal ownership, are transferred to the Company are classified as finance leases. Finance leases are capitalised by recording an asset and a liability equal to the present value of the minimum lease payments including any guaranteed residual values. Leased assets are depreciated on a straight-line basis over their estimated useful lives where it is likely that the Company will obtain ownership of the asset. Lease payments are allocated between the reduction of the lease liability and the lease interest expense for the period.

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

(j) Unexpended Grants

The Company receives grant monies to fund projects either for contracted periods of time or for specific projects irrespective of the period of time required to complete those projects. It is the policy of the Company to treat grant monies as unexpended grants in the statement of financial position where the Company is contractually obliged to provide the services in a subsequent financial period to when the grant is received or in the case of specific project grants where the project has not been completed.

(k) Financial instruments

Initial recognition and measurement

1 Summary of Significant Accounting Policies (continued)

Financial assets and financial liabilities are recognised when the Company becomes a party to the contractual provisions of the instrument. For financial assets, this is the equivalent to the date that the Company 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 fair value, amortised cost using the effective interest rate method, or cost. 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 the amount at which the financial asset or financial liability is measured at initial recognition less principal repayments and any reduction for impairment, and adjusted for any cumulative amortisation of the difference between that initial amount and the maturity amount calculated using the *effective interest method*.

The *effective interest method* is used to allocate interest income or interest expense over the relevant period and is equivalent to the rate that 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 amount with a consequential recognition of an income or expense item in profit or loss.

(i) *Financial assets at fair value through profit or loss*

Financial assets are classified at ‘fair value through profit or loss’ when they are held for trading for the purpose of short-term profit taking, derivatives not held for hedging purposes, or when they are designated as such to avoid an accounting mismatch or to enable performance evaluation where a group of financial assets is managed by key management personnel on a fair value basis in accordance with a documented risk management or investment strategy. Such assets are subsequently measured at fair value with changes in carrying amount being included in profit or loss.

(ii) *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. Gains or losses are recognised in profit or loss through the amortisation process and when the financial asset is derecognised.

(iii) *Held-to-maturity investments*

Held-to-maturity investments are non-derivative financial assets that have fixed maturities and fixed or determinable payments, and it is the Company's intention to hold these investments to maturity. They are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial asset is derecognised.

(iv) *Available-for-sale investments*

Available-for-sale investments are non-derivative financial assets that are either not capable of being classified into other categories of financial assets due to their nature, or they are designated as such by management. They comprise investments in the equity of other entities where there is neither a fixed maturity nor fixed or

1 Summary of Significant Accounting Policies (continued)

determinable payments.

They are subsequently measured at fair value with any remeasurements other than impairment losses and foreign exchange gains and losses recognised in other comprehensive income. When the financial asset is derecognised, the cumulative gain or loss pertaining to that asset previously recognised in other comprehensive income is reclassified into profit or loss.

Available-for-sale financial assets are included in non-current assets when they are expected to be sold within 12 months after the end of the reporting period. All other available-for-sale financial assets are classified as current assets.

(v) *Financial liabilities*

Non-derivative financial liabilities other than financial guarantees are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial liability is derecognised.

Impairment

At the end of each reporting period, the Company assesses whether there is objective evidence that a financial asset has been impaired. A financial asset or a group of financial assets will be deemed to be impaired if, and only if, there is objective evidence of impairment as a result of the occurrence of one or more events (a 'loss event'), which has an impact on the estimated future cash flows of the financial asset(s).

In the case of available-for-sale financial assets, a significant or prolonged decline in the market value of the instrument is considered a loss event. Impairment losses are recognised in profit or loss immediately. Also, any cumulative decline in fair value previously recognised in other comprehensive income is reclassified to profit or loss at this point.

In the case of financial assets carried at amortised cost, loss events may include indications that the debtors, or a group of debtors, are experiencing significant financial difficulty, default or delinquency in interest or principal payments, indications that they will enter into bankruptcy or other financial reorganisation and changes in arrears or economic conditions that correlate with defaults.

For financial assets carried at amortised cost (including loans and receivables), a separate allowance account is used to reduce the carrying amount of financial assets impaired by credit losses. After having undertaken all possible measures of recovery, if the management establishes that the carrying amount cannot be recovered by any means, at that point the written-off amounts are charged to the allowance account or the carrying amount of impaired financial assets is reduced directly if no impairment amount was previously recognised in the allowance account.

When the terms of financial assets that would otherwise have been past due or impaired have been renegotiated the Company recognises the impairment for such financial assets by taking into account the original terms as if the terms have not been renegotiated so that the loss events that have occurred are duly considered.

Derecognition

Financial assets are derecognised where the contractual rights to receipt of cash flows expire or the asset is transferred to another party whereby the Company 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 discharged, cancelled or have expired. The difference between the carrying amount 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.

1 Summary of Significant Accounting Policies (continued)

(l) Fair Value of Assets and Liabilities

The Company measures some of its assets and liabilities at fair value on either a recurring or non-recurring basis, depending on the requirements of the applicable Accounting Standard.

Fair value is the price the Company would receive to sell an asset or would have to pay to transfer a liability in an orderly (ie unforced) transaction between independent, knowledgeable and willing market participants at the measurement date.

As fair value is a market-based measure, the closest equivalent observable market pricing information is used to determine fair value. Adjustments to market values may be made having regard to the characteristics of the specific asset or liability. The fair values of assets and liabilities that are not traded in an active market are determined using one or more valuation techniques. These valuation techniques maximise, to the extent possible, the use of observable market data.

To the extent possible, market information is extracted from either the principal market for the asset or liability (ie the market with the greatest volume and level of activity for the asset or liability) or, in the absence of such a market, the most advantageous market available to the Company at the end of the reporting period (ie the market that maximises the receipts from the sale of the asset or minimises the payments made to transfer the liability, after taking into account transaction costs and transport costs).

For non-financial assets, the fair value measurement also takes into account a market participant's ability to use the asset in the highest and best use or to sell it to another market participant that would use the asset in its highest and best use.

The fair value of liabilities and the Company's own equity instruments (excluding those related to share-based payment arrangements) may be valued, where there is no observable market price in relation to the transfer of such financial instruments, by reference to observable market information where such instruments are held as assets. Where this information is not available, other valuation techniques are adopted and, where significant, are detailed in the respective note to the financial statements.

(m) Revenue and other income

Non-reciprocal grant revenue is recognised in profit or loss when the Company obtains control of the grant and it is probable that the economic benefits gained from the grant will flow to the Company and the amount of the grant can be measured reliably.

If conditions are attached to the grant which must be satisfied before it is eligible to receive the contribution, the recognition of the grant as revenue will be deferred until those conditions are satisfied.

Revenue recognition relating to the provision of services is determined with reference to the stage of completion of the transaction at the end of the reporting period and where the outcome of the contract can be estimated reliably. Stage of completion is determined with reference to the services performed to date as a percentage of total anticipated services to be performed. Where the outcome cannot be estimated reliably, revenue is recognised only to the extent that related expenditure is recoverable.

Revenue from the sale of goods is recognised at the point of delivery as this corresponds to the transfer of significant risks and rewards of ownership of the goods and the cessation of all involvement in those goods.

Interest revenue is recognised using the effective interest method. Membership income is recognised on a receipts basis as it is voluntary in nature.

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

1 Summary of Significant Accounting Policies (continued)

(n) Income Tax

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

(o) Goods and Services Tax (GST)

Revenues, expenses and assets are recognised net of the amount of GST, except where the amount of GST incurred is not recoverable from the Australian Taxation Office (ATO).

Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount GST recoverable from, or payable to, the ATO is included with other receivables or payables in the statement of financial position.

Cash flows are presented on a gross basis. The GST components of cash flows arising from investing or financing activities which are recoverable from, or payable to, the ATO are presented as operating cash flows included in receipts from customers or payments to suppliers.

(p) Comparative Figures

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

When the Company retrospectively applies an accounting policy, makes a retrospective restatement or reclassifies items in its financial statements, an additional statement of financial position as at the beginning of the preceding comparative period, in addition to the minimum comparative financial statements, must be disclosed.

(q) Critical accounting estimates and judgments

The directors evaluate estimates and judgments incorporated into the financial statements based on historical knowledge and best available current information. Estimates assume a reasonable expectation of future events and are based on current trends and economic data, obtained both externally and within the Company.

Key estimates - impairment

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

(r) Economic dependence

Consumers Health Forum of Australia Ltd is dependent on Australian Government funding from the Department of Health for the majority of its revenue used to operate the business. At the date of this report the directors have no reason to believe the Australian Government will not continue to support Consumers Health Forum of Australia Ltd via its funding agreements with the Department of Health.

(s) New Accounting Standards and Interpretations

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

1 Summary of Significant Accounting Policies (continued)

(s) New Accounting Standards and Interpretations (continued)

Standard Name	Effective date for entity	Requirements	Impact
AASB 9 Financial Instruments AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2009) AASB 2012 6 Amendments to Australian Accounting Standards - Mandatory Effective Date of AASB 9 and Transitional Disclosures AASB 2013-9 Amendments to Australian Accounting Standards - Conceptual Framework, Materiality and Financial Instruments	30 June 2018	Significant revisions to the classification and measurement of financial assets, reducing the number of categories and simplifying the measurement choices, including the removal of impairment testing of assets measured at fair value. The amortised cost model is available for debt assets meeting both business model and cash flow characteristics tests. All investments in equity instruments using AASB 9 are to be measured at fair value.	The available-for-sale investments held will be classified as fair value through OCI and will no longer be subject to impairment testing. Other impacts on the reported financial position and performance have not yet been determined.
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 address inconsistencies identified in applying some of the offsetting criteria of AASB 132, including clarifying the meaning of 'currently has a legally enforceable right of set off' and that some gross settlement systems may be considered equivalent to net settlement.	The adoption of this standard will not change the reported financial position and performance of the entity, there are no impact on disclosures as there are no offsetting arrangements currently in place.
AASB 2013-3 Amendments to AASB 136 - Recoverable Amount Disclosures for Non-Financial Assets	30 June 2015	This standard amends AASB 136 to require additional disclosures about the fair value measurement when the recoverable amount of impaired assets is based on fair value less costs of disposal. In addition, a further requirement has been included to disclose the discount rates that have been used in the current and previous measurements if the recoverable amount of impaired assets based on fair value less costs of disposal was measured using a present value technique.	There are no changes to reported financial position or performance from AASB 2013-3, however additional disclosures may be required.
AASB 2013-9 Amendments to Australian Accounting Standards - Conceptual Framework, Materiality and Financial Instruments AASB 2014-1 Amendments to Australian Accounting Standards	30 June 2015	This standard withdraws the substantive content in AASB 1031 and provides signpost references to materiality in other Australian Accounting Standards. AASB 2014 1 makes amendments to particular Australian Accounting Standards to delete their references to AASB 1031 Materiality as each standard is amended for another purpose.	There is not expected to be any changes to the reported financial position, performance or cash flows of the entity.

2 Cash and cash equivalents

	Note	2014 $	2013 $
CURRENT			
Cash on hand		**150**	150
Cash at bank		**1,015,696**	1,901,867
	12, 15	**1,015,846**	1,902,017

3 Trade and other receivables

	Note	2014 $	2013 $
CURRENT			
Trade receivables	15	**241,314**	601,928
Total current trade and other receivables		**241,314**	601,928

(a) Provision for Impairment of Receivables

Current trade receivables are generally on 30-day terms. These receivables are assessed for recoverability and a provision for impairment is recognised when there is objective evidence that an individual trade receivable is impaired. No provision for impairment was required at year end.

(b) Credit risk - Trade and Other Receivables

The Company 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 3. The main source of credit risk to the Company is considered to relate to the class of assets described as 'trade and other receivables'.

The following table details the Company's trade and other receivables exposed 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 within the terms and conditions agreed between the Company and the customer or counterparty to the transaction. Receivables that are past due are assessed for impairment by ascertaining solvency of the debtors and are provided for where there are specific circumstances indicating that the debt may not be fully repaid to the Company. The balances of receivables that remain within initial trade terms (as detailed in the table) are considered to be of high credit quality.

			Past due but not impaired (days overdue)				
	Gross amount	Past due and impaired	< 30	31-60	61-90	> 90	Within initial trade terms
	$	$	$	$	$	$	$
2014							
Trade and other receivables	**241,314**	**-**	**146,019**	**-**	**-**	**-**	**95,295**
2013							
Trade and other receivables	601,928	-	-	-	-	37,752	564,176

4 Other financial assets

	Note	2014 $	2013 $
CURRENT			
Held-to-maturity financial assets	4(a)	**1,526,045**	26,045
Total current assets		**1,526,045**	26,045

(a) Held-to-maturity investments comprise:

	Note	2014 $	2013 $
Fixed interest securities - current	15	**1,526,045**	26,045
		1,526,045	26,045

5 Other assets

	Note	2014 $	2013 $
CURRENT			
Prepayments		**23,943**	16,892
		23,943	16,892

6 Property, plant and equipment

	Note	2014 $	2013 $
Office equipment			
At cost		**27,738**	6,336
Accumulated depreciation		**(6,962)**	(2,907)
Total office equipment		**20,776**	3,429
Member/Contact database			
At cost		**12,400**	12,400
Accumulated depreciation		**(4,749)**	(2,269)
Total member/contact database		**7,651**	10,131
Leasehold improvements			
At cost		**17,082**	17,082
Accumulated depreciation		**(11,861)**	(6,168)
Total leasehold improvements		**5,221**	10,914
Total property, plant and equipment		**33,648**	24,474

6 Property, plant and equipment (continued)

(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:

	Office equipment	Member/Contact database	Leasehold improvements	Total
	$	$	$	$
Year ended 30 June 2014				
Balance at the beginning of year	**3,429**	**10,131**	**10,914**	**24,474**
Additions	**21,402**	**-**	**-**	**21,402**
Depreciation expense	**(4,055)**	**(2,480)**	**(5,693)**	**(12,228)**
Balance at the end of the year	**20,776**	**7,651**	**5,221**	**33,648**
Year ended 30 June 2013				
Balance at the beginning of year	5,541	-	16,607	22,148
Additions	-	12,400	-	12,400
Depreciation expense	(2,112)	(2,269)	(5,693)	(10,074)
Balance at the end of the year	3,429	10,131	10,914	24,474

7 Trade and other payables

	Note	2014 $	2013 $
CURRENT			
Unsecured liabilities			
Trade payables		**151,896**	75,069
Accrued expenses		**41,305**	85,482
Deferred income		**279,403**	473,339
GST payable		**20,969**	103,245
		493,573	737,135

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

	Note	2014 $	2013 $
Trade and other payables:			
- total current		**493,573**	737,135
Less:			
GST payable		**(20,969)**	(103,245)
Deferred income		**(279,403)**	(473,339)
Financial liabilities as trade and other payables	15	**193,201**	160,551

8 Provisions

	Note	2014 $	2013 $
CURRENT			
Annual leave entitlements		**45,636**	67,354
		45,636	67,354
NON-CURRENT			
Long service leave entitlements		**5,662**	8,905
		5,662	8,905

Analysis of total provisions

	Note	2014 $	2013 $
Current		**45,636**	67,354
Non-current		**5,662**	8,905
		51,298	76,259

	Annual leave entitlements $	Long service leave entitlements $	Total $
Balance at 30 June 2014	**45,636**	**-**	**45,636**

	Annual leave entitlements $	Long service leave entitlements $	Total $
Balance at 30 June 2014	**-**	**5,662**	**5,662**

Employee Provisions

Employee provisions represent amounts accrued for annual leave and long service leave.

The current portion for this provision includes the total amount accrued for annual leave entitlements and the amounts accrued for long service leave entitlements that have vested due to employees having completed the required period of service. Based on past experience, the Company does not expect the full amount of annual leave or long service leave balances classified as current liabilities to be settled within the next 12 months. However, these amounts must be classified as current liabilities since the Company does not have an unconditional right to defer the settlement of these amounts in the event employees wish to use their leave entitlement.

The non-current portion for this provision includes amounts accrued for long service leave entitlements that have not yet vested in relation to those employees who have not yet completed the required period of service.

9 Revenue and Other Income

	Note	2014 $	2013 $
Revenue			
- grant revenue		**2,827,447**	2,702,507
- member subscriptions		**41,883**	51,610
- other income		**161,161**	19,424
- interest received		**58,447**	33,446
- contribution received - CHF Inc		**-**	839,691
Total Revenue		**3,088,938**	3,646,678

10 Profit (loss) for the Year

Profit (loss) includes the following specific expenses:

	Note	2014 $	2013 $
Administrative expenses			
- Campaigns		**44,851**	1,762
- Communications		**37,819**	38,082
- Corporate Services		**328,047**	290,889
- Governance		**91,620**	123,205
- Membership		**250**	-
- Other Grant Expenses		**65,762**	22,780
- Other Grant Expenses - Consultancy		**372,521**	111,209
- Other Grant Expenses - Workshop Costs		**221,260**	319,812
Total administrative expenses		**1,162,130**	907,739
Rental expense on operating leases:			
- Minimum lease payments		**114,599**	102,855

11 Remuneration of Auditors

	Note	2014 $	2013 $
Remuneration of the auditor of the Company for:			
- auditing or reviewing the financial report		**6,740**	10,200

12 Cash Flow Information

(a) Reconciliation of cash

	Note	2014 $	2013 $
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:			
Cash and cash equivalents	2	**1,015,846**	1,902,017
		1,015,846	1,902,017

(b) Reconciliation of Cash Flow from Operations with Profit (loss) after Income Tax

	Note	2014 $	2013 $
Profit for the year		**537,963**	1,410,379
Non-cash flows in profit:			
- depreciation		**12,228**	10,074
Changes in assets and liabilities:			
- (increase)/decrease in trade and other receivables		**360,614**	(242,393)
- (increase)/decrease in prepayments		**(7,051)**	6,202
- increase/(decrease) in deferred income		**(193,936)**	(143,942)
- increase/(decrease) in trade and other payables		**(49,626)**	57,193
- increase/(decrease) in provisions		**(24,961)**	5,076
Cash flow from operations		**635,231**	1,102,589

(c) Credit standby arrangements with banks

	Note	2014 $	2013 $
Credit facility		**14,000**	14,000
Amount utilised		**(3,586)**	(8,252)
		10,414	5,748

12 Cash Flow Information (continued)

(c) Credit standby arrangements with banks (continued)

The Company has credit card facilities setup with their bank with general terms and conditions. Interest rates are variable and subject to adjustment.

(d) Non-cash financing and investing activities

There were no non-cash financing or investing activities during the year.

13 Capital and Leasing Commitments

(a) Operating Lease Commitments

Non-cancellable operating leases contracted for but not recognised in the financial statements:

	Note	2014 $	2013 $
Payable - minimum lease payments			
- not later than 12 months		**109,649**	125,836
- between 12 months and 5 years		**107,309**	221,949
		216,958	347,785

The property lease is a non-cancellable lease with a 3 year term expiring on 14 May 2016, with rent payable monthly in advance. Contingent rental provisions within the lease agreement require the minimum lease payments shall be increased by CPI per annum.

The other operating lease is a non-cancellable lease with a 4 year term and fixed monthly payments.

14 Key Management Personnel Compensation

Any person(s) having authority and responsibility for planning, directing and controlling the activities of the Company, directly or indirectly, including any director is considered key management personnel.

The totals of remuneration paid to the key management personnel of the Company during the year are as follows:

	Note	2014 $	2013 $
Short-term benefits		**278,026**	343,208
Long-term benefits		**-**	2,750
		278,026	345,958

15 Financial Risk Management

The Company's financial instruments consist mainly of deposits with banks, short-term investments, accounts receivable and payable.

15 Financial Risk Management (continued)

The carrying amounts 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:

	Note	2014 $	2013 $
Financial Assets			
Cash and cash equivalents	2	**1,015,846**	1,902,017
Loans and receivables	3	**241,314**	601,928
Held-to-maturity investments	4	**1,526,045**	26,045
Total financial assets		**2,783,205**	2,529,990
Financial Liabilities			
Financial liabilities at amortised cost			
- Trade and other payables	7(a)	**193,201**	160,551
Total financial liabilities		**193,201**	160,551

Financial Risk Management Policies

The directors' risk management strategy seeks to assist the Company in meeting its financial targets whilst minimising potential adverse effects on financial performance. Risk management policies are approved and reviewed by the directors on a regular basis. These include credit risk policies and future cash flow requirements.

Specific financial risk exposures and management

The main risks the Company is exposed to through its financial instruments are credit risk, liquidity risk and market risk relating to interest rate risk.

There have been no substantive changes in the types of risks the Company is exposed to, how these risks arise, or the director's objectives, policies and processes for managing or measuring the risks from the previous period.

(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 the Company.

Credit risk is managed through the maintenance of procedures ensuring to the extent possible, that customers and counterparties to transactions are of sound credit worthiness. Such monitoring is used in assessing receivables for impairment. Credit terms are generally 30 days from the invoice date.

Risk is also minimised through investing surplus funds in financial institutions that maintain a high credit rating.

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.

15 Financial Risk Management (continued)

(a) Credit risk (continued)

The Company 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 3.

Trade and other receivables that are neither past due nor impaired are considered to be of high credit quality. Aggregates of such amounts are as detailed at Note 3.

Credit risk related to balances with banks and other financial institutions is managed by the directors. The following table provides information regarding credit risk relating to cash and money market securities based on Standard & Poor's counterparty credit ratings.

	Note	2014 $	2013 $
Cash and cash equivalents			
- AA Rated	2	**1,015,696**	1,901,867
		1,015,696	1,901,867
Held to maturity securities			
- AA Rated	4	**1,526,045**	26,045
		1,526,045	26,045

(b) Liquidity risk

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

- preparing forward-looking cash flow analysis in relation to its operational, investing and financial activities;
- monitoring undrawn credit facilities;
- maintaining a reputable credit risk 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.

The table below reflect an undiscounted contractual maturity analysis for financial liabilities. Cash flows realised from financial assets reflect management's expectation as to the timing of realisation. Actual timing may therefore differ from that disclosed. The timing of cash flows presented in the table to settle financial liabilities reflects the earliest contractual settlement dates.

15 Financial Risk Management (continued)

(b) Liquidity risk (continued)

	Within 1 Year		1 to 5 Years		Over 5 Years		Total	
	2014	2013	2014	2013	2014	2013	2014	2013
	$	$	$	$	$	$	$	$
Financial liabilities due for payment								
Trade and other payables (excluding deferred income and GST payable)	**193,201**	160,551	**-**	-	**-**	-	**193,201**	160,551
Total contractual outflows	**193,201**	160,551	**-**	-	**-**	-	**193,201**	160,551
Financial assets - cash flows realisable								
Cash and cash equivalents	**1,015,846**	1,902,017	**-**	-	**-**	-	**1,015,846**	1,902,017
Trade, term and loans receivables	**241,314**	601,928	**-**	-	**-**	-	**241,314**	601,928
Held-to-maturity investments	**1,526,045**	26,045	**-**	-	**-**	-	**1,526,045**	26,045
Total anticipated inflows	**2,783,205**	2,529,990	**-**	-	**-**	-	**2,783,205**	2,529,990

(c) Market risk

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 Company is also exposed to earnings volatility on floating rate instruments.

Sensitivity analysis

The following table illustrates sensitivities to the Company's exposures to changes in interest rates. The table indicates the impact on how profit or loss and equity values reported at the end of the reporting period would have been affected by changes in the relevant risk variable that management considers to be reasonably possible. These sensitivities assume that the movement in a particular variable is independent of other variables.

	Profit	Equity
	$	$
Year ended 30 June 2014		
+/- 2% in interest rates	**50,000**	**50,000**
Year ended 30 June 2013		
+/- 2% in interest rates	38,000	38,000

There have been no changes in any of the assumptions used to prepare the above sensitivity analysis from the prior year.

Fair values

Fair value estimation

15 Financial Risk Management (continued)

The fair values of financial assets and financial liabilities approximate their carrying values as presented in the statement of financial position and notes to the financial statements. Fair value is the amount at which an asset could be exchanged, or a liability settled, between knowledgeable, willing parties in an arm's length transaction.

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.

Differences between fair values and carrying amounts of financial instruments with fixed interest rates are due to the change in discount rates being applied by the market since their initial recognition by the Company. Most of these instruments which are carried at amortised cost are to be held until maturity and therefore the fair value figures calculated bear little relevance to the Company.

The fair values of financial assets and financial liabilities as disclosed in the statement of financial position and in the notes to the financial statements have been determined based on the following methodologies: Cash and cash equivalents, trade and other receivables and trade and other payables are short-term instruments in nature whose carrying value is equivalent to fair value. Trade and other payables exclude deferred income and GST payable which are not considered to be financial instruments.

16 Capital Management

The directors control the capital of the Company to ensure that adequate cash flows are generated to fund its operations and that returns from investments are maximised within tolerable risk parameters. The directors' ensure that the overall risk management strategy is in line with this objective.

The Company's capital consists of financial liabilities, supported by financial assets.

The directors effectively manage the Company's capital by assessing the Company's financial risks and responding to changes in these risks and in the market. These responses may include the consideration of debt levels.

There have been no changes to the strategy adopted by the directors to control the capital of the Company since the previous year.

The gearing ratios for the years ended 30 June 2014 and 30 June 2013 are as follows:

	Note	2014 $	2013 $
Total borrowings		**-**	-
Less Cash and cash equivalents	2	**(1,015,846)**	(1,902,017)
Net debt		**(1,015,846)**	(1,902,017)
Equity		**2,295,925**	1,757,962
Total capital		**1,280,079**	(144,055)
Gearing ratio		**- %**	- %

17 Company Details

The registered office of the Company is:
Consumers Health Forum of Australia Ltd
Unit 9, 11 National Circuit
Barton ACT 2600

Consumers Health Forum of Australia Ltd

ABN 82 146 988 927

Directors' Declaration

The directors of the Company declare that:

1. The financial statements and notes, as set out on pages 7 to 29, are in accordance with the *Corporations Act 2001* and:

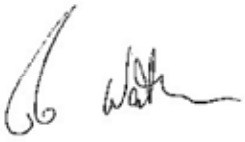
   (a) comply with Australian Accounting Standards; and

   (b) give a true and fair view of the financial position of the Company as at 30 June 2014 and of its performance for the year ended on that date.

2. In the directors' opinion, there are reasonable grounds to believe that the Company will be able to pay its debts as and when they become due and payable.

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

Director: .....
Tony Lawson



Director: .....
Jo Watson

Dated: 17 October 2014

Hardwickes
more than accounting

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Hardwickes
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Hardwickes Partners Pty Ltd
ABN 21 008 401 536

Liability limited by a scheme approved under Professional Standards Legislation

Independent Auditor's Report

To the members of Consumers Health Forum of Australia Ltd

Report on the Financial Report

We have audited the accompanying financial report of Consumers Health Forum of Australia Ltd, which comprises the statement of financial position as at 30 June 2014, 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 the directors' declaration.

Directors' Responsibility for the Financial Report

The directors of the Company are responsible for the preparation of the financial report that gives a true and fair view in accordance with Australian Accounting Standards and the *Corporations Act 2001* and for such internal control as the directors determine is necessary to enable the preparation 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 Company's preparation of the financial report that gives a true and fair view 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 Company's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the directors, as well as evaluating the overall presentation of the financial report.

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

Independence

In conducting our audit, we have complied with the independence requirements of the *Corporations Act 2001*.

Hardwickes
more than accounting

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To the members of Consumers Health Forum of Australia Ltd

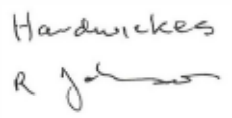
Opinion

In our opinion the financial report of Consumers Health Forum of Australia Ltd is in accordance with the *Corporations Act 2001*, including:

(a) giving a true and fair view of the Company's financial position as at 30 June 2014 and of its performance for the year ended on that date; and

(b) complying with Australian Accounting Standards and the *Corporations Regulations 2001*.

Hardwickes
Chartered Accountants



Robert Johnson FCA
Partner

Canberra

Dated: 17 October 2014

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