S·A·R·R·A·H
Services for Australian
Rural and Remote Allied Health

ANNUAL REPORT 2015–2016

ANNUAL REPORT 2015-2016

BACKGROUND STORY

The approach for the design of the 2015–16 SARRAH Annual Report is about transformation and focusing on key issues facing the rural and remote allied health sector. It is intended to convey the dynamic and responsive nature of allied health professionals (AHPs) and how SARRAH addresses the grass-roots needs of people working in the bush.

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SERVICES FOR AUSTRALIAN RURAL AND REMOTE ALLLIED HEALTH (SARRAH)

SARRAH is a national, multidisciplinary member association, supporting allied health professionals to improve health outcomes in rural and remote communities throughout Australia. SARRAH has been operating for 20 years and is the only peak body to be fully focused on rural and remote allied health working across all disciplines.

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01 INTRODUCTION

Thank you to all SARRAH members - students, allied health professionals and organisations. It is only with the active support of all members that SARRAH can continue to represent and influence allied health reforms in rural and remote Australia.

WELCOME TO SARRAH

Welcome to the 2015-16 annual report for Services for Australian Rural and Remote Allied Health (SARRAH).

During 2015–16 SARRAH continued its focus on research to support rural and remote allied health services and maintained a high level of engagement in rural and remote health policy. SARRAH also expanded its membership base to include organisations who share our vision for supporting rural and remote Australian communities. While SARRAH will not receive core funding from the Federal Government after 30 June 2016, the support of corporate members and individual members will assist SARRAH to continue its work in enabling Australians living in rural and remote communities to have access to allied health services that support equitable and sustainable health and wellbeing.

SARRAH was established in 1995 and is nationally recognised as the peak body representing rural and remote Allied Health Professionals (AHPs) who work in the public and private sectors. The organisation develops and provides services that enable its members to confidently and competently carry out their professional duties. AHPs deliver a range of clinical and health education services to people who reside in the bush.

SARRAH's membership comprises the following allied health professions:

Audiology	Medical Imaging	Paramedics
Chinese Medicine	Nuclear Medicine	Pharmacy
Chiropractic	Radiation Therapy	Physiotherapy
Dental and Oral Health	Health Promotion	Podiatry
Dentistry	Occupational Therapy	Prosthetics
Dietetics and Nutrition	Optometry	Psychology
Diabetes Education	Orthoptics	Speech Pathology
Exercise Physiology	Orthotics	Social Work
Genetic Counselling	Osteopathy	Sonography

SARRAH is committed to providing support for AHPs in all sectors. To achieve this objective, it has established an extensive regional, state and national network of AHPs, who live and work in rural and remote communities and encompass a broad spectrum of allied health services.

As the peak body representing AHPs in rural and remote practice, SARRAH recognises the tertiary qualifications of AHPs. SARRAH supports the application of their clinical skills to diagnose, assess, treat, manage and prevent illness and injury.

Moving into the future, SARRAH maintains that every Australian should have access to equitable health services regardless of where they live; and that allied health services are basic and fundamental to the wellbeing of all Australians.

WELCOME TO SARRAH

Mission

SARRAH exists so that rural and remote Australian communities have allied health services that support equitable and sustainable health and wellbeing.

Vision

It is our vision that SARRAH will be the recognised peak body representing and influencing reform in rural and remote allied health, with a supported and dynamic member network.

Values

The articulation of the fundamental values that distinguish SARRAH as an organisation is important to underpin the achievement of SARRAH's primary objective, and the prioritisation of organisational activities and resource allocation. This articulation of values we call 'our' perspective includes actions such as:

- Inclusiveness
- Fairness
- Equity
- Advocacy
- Respect.

SARRAH provides individual rural and remote AHPs with opportunities to inform and influence, by contributing 'our' perspective to policy and planning processes that govern service delivery to rural and remote communities with the ultimate goal being enhanced community health outcomes.

'Our' perspective is demonstrated by qualities such as:

- Valuing the individual grassroots AHP
- Consultation
- Achievement orientation
- Connectedness to community
- Can-do attitude.

PRESIDENT'S REPORT

I am proud to present the SARRAH Annual Report for 2015–16. SARRAH has been resilient in the face of uncertainty during this operating year.

We continue to go through a transformative process to reprioritise and broaden engagement with our membership to have a direct impact on the rural and remote allied health workforce.

This year, the SARRAH Board worked with CEO Rod Wellington to diversify SARRAH's income streams in the face of being unsuccessful in tendering for the Health and Peak Advisory Bodies Program in 2015. By diversifying our income, SARRAH will be primed to become a stronger voice to advocate on behalf of people struggling with the health inequality they face in the bush. I thank Rod Wellington and the secretariat staff for the work they have done over the course of the year.

This year SARRAH:

- Endorsed a revised risk management plan, 2016–19 strategic plan and a six-month operational plan covering SARRAH's operations until December 2016
- Convened its seventh Summit in Canberra where delegates had the opportunity to share their experiences with Federal members of parliament
- Worked collectively with the Parliamentary Friendship Group for Rural and Remote Allied Health on several occasions, informing the discussion on developing resilient rural allied health workforce policy
- Completed a number of significant research projects focusing on quantifying the economic benefits of providing access to key allied health services to manage chronic disease
- Continued providing support to 884 new and existing AHP and student scholarship recipients and giving them the means to develop, learn and succeed in rural and remote communities
- Increased sector representation through our corporate membership program. Eighteen universities and seven organisations from across the allied health sector have supported SARRAH in 2015–16.

At the 2015 AGM held during the SARRAH Summit, we farewelled Ruth Chalk and welcomed Clare Salter and Kerstin McPherson to the Board.

It has been a great honour and privilege to serve on the SARRAH Board for the past seven years including four years as President, so it is with mixed emotions that I have decided to step down to make way for new leadership. SARRAH is a strong, resilient, influential and highly respected organisation. In the face of ongoing health sector challenges and reforms, SARRAH continues to be the relevant can-do voice of rural and remote allied health. With your support, SARRAH will continue to shape Australia's health system, improve access to rural and remote AHP services, and positively impact the health and wellbeing of the communities we serve. Thank you all for your support and commitment to this important mission.

Tanya Lehmann
President

SARRAH ORGANISATION OVERVIEW INFOGRAPHICS

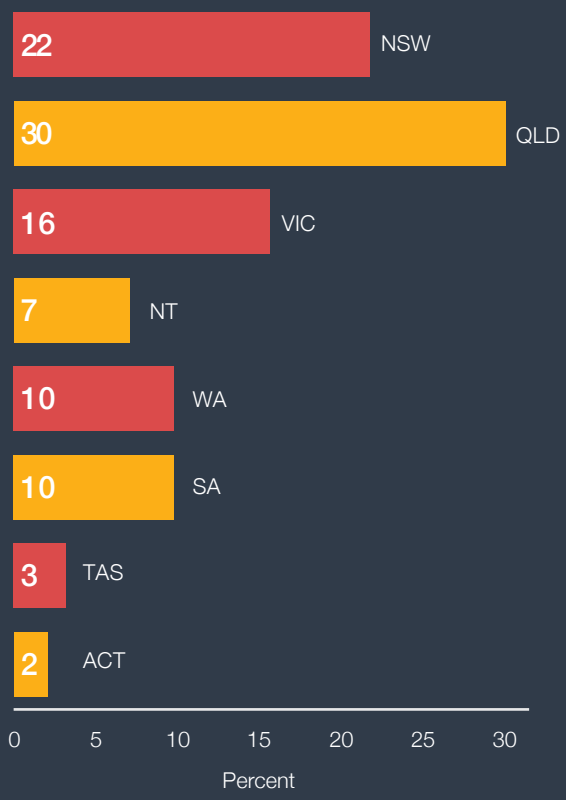
Member representation

26 percent
SARRAH membership growth rate achieved in 2015-16

25 health
sector organisations joined SARRAH as corporate members in 2015-16

27 allied
professions represented by SARRAH and its members

Geographic distribution of membership in 2015-16



Nursing and Allied Health Scholarship Support Scheme

884
current scholars over three streams as at 30 June 2016

548
scholarships awarded to eligible applicants in 2015-16

34%
cut to NAHSSS funding

3,035
scholarship applications received from eligible scholars in 2015-16

326
scholarship places lost as a result of funding cuts in 2015-16

Research and Policy Development

15 meetings
with parliamentarians covering a range of topics including healthcare reform

3 position
papers developed by the SARRAH Advisory Committee

9 submissions
developed in consultation with members to address health policy matters

2 research
reports publicly released highlighting importance of allied health care

Media and Community Engagement

8 media releases
4 articles
9 interviews
3 public speaking appearances
3 website publications

1,765
Facebook Likes

25%
increase in average Facebook reach

200+
social media posts in 2015-16

26 newsletters
12 e-bulletins, **6** board meeting communiques and **8** special broadcasts were published in 2015-16

SARRAH Summit

4
day summit

17
delegates attended

10
parliamentary meetings

4
priority areas identified

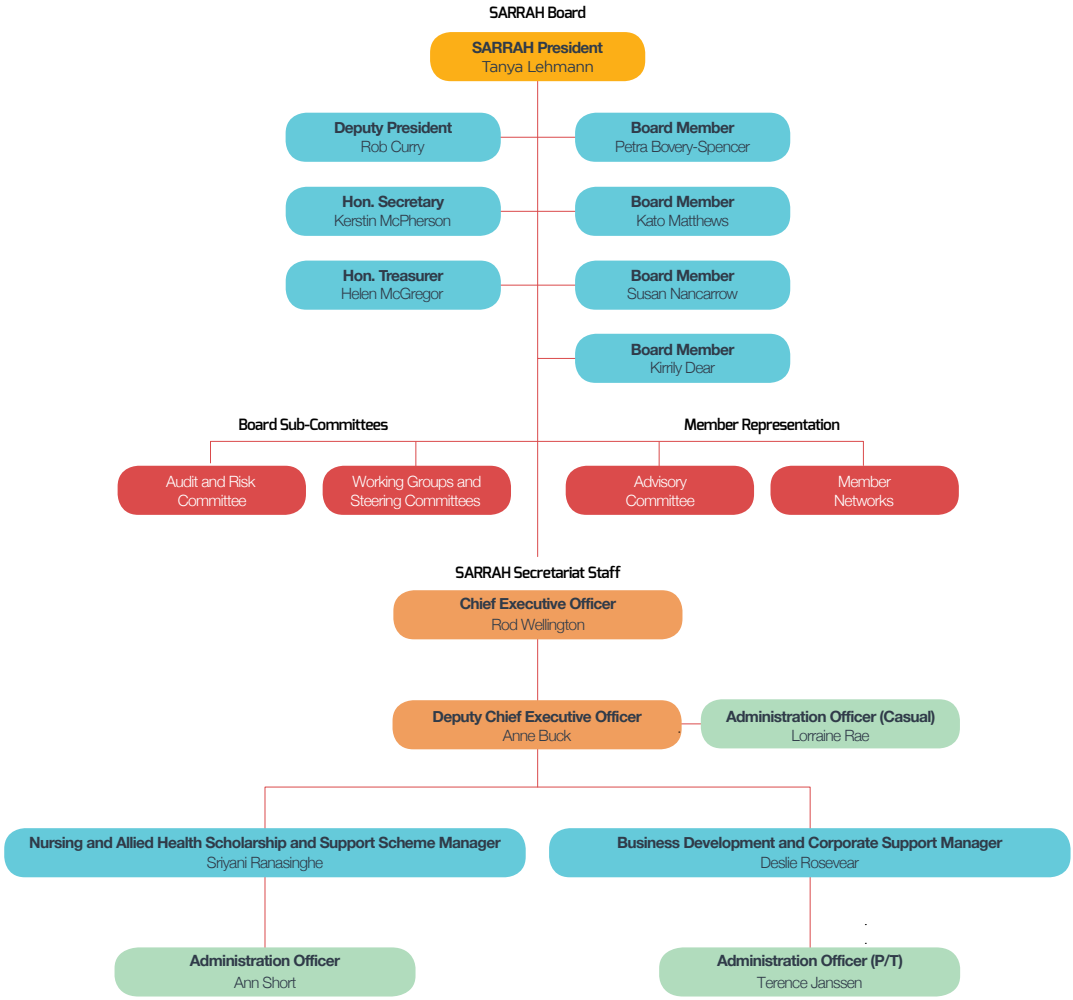
02 CORPORATE GOVERNANCE

Support from the corporate sector enables SARRAH to achieve our goals in a way that is sustainable, including preserving the ability to consult broadly across the sectoral and grass-roots level. With the support of our corporate members we can continue to advocate for change at the local, state and federal levels.

ORGANISATION STRUCTURE

SARRAH is governed by the Board of Directors, supported by committees, working groups and the Secretariat, working together to achieve the strategic goals of the organisation.

Figure 1: Organisation structure



ORGANISATION STRUCTURE

SARRAH Board

The SARRAH Board provides governance and oversight over the affairs, property and funds of SARRAH. Members of the Board have the authority to interpret the meaning of the Constitution and any matter on which the Constitution is silent. The Board is also responsible for appointing the CEO and determining SARRAH's strategic direction.

The SARRAH Board comprises nine members. In 2015–16 the Board membership was as follows:

Name	Position	Appointment
Tanya Lehmann	President	Appointed at 2014 AGM
Rob Curry	Deputy President	Appointed at 2014 AGM
Kerstin McPherson	Honorary Secretary	Appointed at 2014 AGM
Helen McGregor	Honorary Treasurer	Appointed at 2014 AGM
Petra Bovery-Spencer	Board Member	Appointed at 2014 AGM
Kirrily Dear	Board Member	Appointed in March 2015
Kato Matthews	Board Member	Appointed at 2014 AGM
Susan Nancarrow	Board Member	Appointed at 2014 AGM
Claire Salter	Board Member	Appointed at 2014 AGM

Audit and Risk Committee

The Audit and Risk Committee helps assure accountability in assisting SARRAH to comply with obligations under the Constitution, and provides a forum for discussion about compliance, risk management and stakeholder reporting. The Audit and Risk Committee membership in 2015–16 was as follows:

Name	Position
Helen McGregor (Chair)	Appointed in 2015
Petra Bovery-Spencer	Appointed in 2014
Rod Wellington	Appointed in 2008
Anne Buck	Appointed in 2015

Advisory Committee

The Advisory Committee is an important part of SARRAH's structure. It provides input and advice to the Board on policy and long-term strategic objectives. It also provides a convenient and accessible forum in which the views of the members can be considered and shared with the Board. The Committee comprises the coordinators of each jurisdiction and discipline network. It is co-chaired by a member of the SARRAH Board and a Network Coordinator.

In 2015–16, the Advisory Committee met six times via teleconference. The Advisory Committee thanks Greg Orphin, Kerstin McPherson, Clare Salter, Kerrie Kelly, Ilana Jorgensen and Katrina Wakely for their contributions.

Key achievements of the Advisory Committee in 2015–16 were:

- Established a SARRAH Facebook Group where Advisory Committee members regularly engage with members
- Developed a SARRAH Position Paper on Models of Allied Health Care in Rural and Remote Australia
- Developed nine submissions to advocate for rural and remote allied health.

The Network Coordinators as at 30 June 2016 are:

Position	Committee Member	Position	Committee Member
NSW Coordinator	Catherine Maloney	Exercise and Sports Science Coordinator	Alex Lawrence
NT Coordinator	Heather Jensen	Medical Imaging Coordinator	Hazel Harries-Jones
SA Coordinator	Kate Osborne	Occupational Therapy Coordinator	Vacant
VIC Coordinator	Kate Roberts	Optometry Coordinator	Luke Arkapaw
QLD Coordinator	Selina Taylor	Oral Health Coordinator	Cathryn Carboon
TAS Coordinator	David Gould	Paramedics Coordinator	Levi Karshimkus
ACT Coordinator	Vacant	Physiotherapy Coordinator	Vacant
WA Coordinator	Vacant	Pharmacy Coordinator	Lindy Swain
Student Coordinator	Ankur Verma	Podiatry Coordinator	Cassandra Bonython
Audiology / Audiometry Coordinator	Vaughan Grigor	Psychology Coordinator	Vacant
Australian Journal of Rural Health	Robyn Glynn	Rural and Remote Allied Health Research Alliance	Narelle Campbell
Dietetics Coordinator	Katherine Cacavas	Social Work Coordinator	Rosalie Kennedy
		Speech Pathology Coordinator	Edward Johnson

ORGANISATION STRUCTURE

2016 Conference Committee

The Conference Committee was formed in January 2015 to oversee the coordination of the 2016 SARRAH National Conference. The conference will take place in Port Lincoln, South Australia from 27 – 29 October 2016. The committee met nine times in 2015–16.

The members of this committee are:

Name	Name
Anna Patterson	Hayley Colyer
Anne Buck	Holly Campbell
Amy Trengrove	Kate Osborne (Chair)
Bronwyn Venning	Meredith Stewart
Deslie Rosevear	Michelle Schilling
Dr Lucylynn Lizarondo	Rod Wellington
Dr Saravana Kumar	Tanya Lehmann
Elaine Ashworth	Verity Paterson

The committee, supported by Conference Design Pty Ltd, developed a conference program structured around the theme of 'It takes a village to raise a child'. The village approach implies that there is shared responsibility and that people work together and contribute in ways that are consistent with their strengths, skills and abilities. At the Conference, delegates will have the opportunity to explore how this village approach can be applied to rural and remote outcomes.

Working groups

SARRAH established a range of working groups comprised of members from the Board and Advisory Committee, who provide input into various projects and activities. In 2015–16 working groups met to complete work related to refining SARRAH's vision and values; improving social media engagement; updating SARRAH's membership services; and enhancing communication of SARRAH achievements.

SARRAH Secretariat

The Secretariat is a small team that supports the governance of the organisation. In 2015–16, SARRAH was unsuccessful in retaining secretariat funding as a result of federal government cuts to the health sector. This has resulted in building upon the organisation restructure of 2014–15 to further streamline operations and reduce administrative overheads.

03 OPERATIONAL OVERVIEW

Universities comprise SARRAH's largest membership base in 2015-16 and they engage with SARRAH through their corporate memberships. As corporate members, universities can raise issues with respect to the rural and remote component of their allied health courses including placements and student support.

CHIEF EXECUTIVE OFFICER'S REPORT

2015–16 proved to be a challenging and an exciting period in which SARRAH continued to be the only peak body fully focusing on rural and remote allied health, working across a range of disciplines.

SARRAH convened a Summit in October 2015. A number of key initiatives were identified to assist in delivering better health results for rural and remote Australia. These initiatives were incorporated into SARRAH's policy and advocacy activities throughout the year.

During the year SARRAH facilitated two research projects. The first project analysed and reported on the economic impact of allied health interventions in the management of chronic diseases. It found that upward of $175M per annum would be saved if people with Diabetes, Stroke and Osteoarthritis received eight specific allied health interventions. The report was launched at Parliament House in Canberra during December 2015.

The second research project commissioned by the NSW Government Ministry of Health required SARRAH to scan the available evidence addressing diabetes-related foot disease amongst Indigenous peoples across NSW. The report recommended that any approach to addressing Indigenous health conditions should consider health within a wider social context, necessitating community ownership of programs, and integration with existing health services and local networks. The report was released in June 2016.

In November 2015, SARRAH was advised that it had been unsuccessful in securing Australian Government funding to support its secretariat, policy and advocacy activities after June 2016. Consequently, SARRAH continued diversifying its income sources, particularly in attracting corporate members – 25 organisations are SARRAH corporate members.

In December 2015, SARRAH joined a panel of three at a National Press Club of Australia forum – Hidden Harms: how concealed budget cuts are killing Australia's health sector. The forum called on the Australian Government to scrap plans to cut nearly $800 million in funding to key health initiatives over the next four financial years.

Administering projects and programs that assist and support rural and remote allied health services remained an important part of SARRAH's operations. As the administrator of the NAHSSS Allied Health Scholarships since 2010, SARRAH awarded and managed around 4,500 scholarship recipients and over $77 million in funding. Unfortunately, the scholarship budget was significantly cut by the Australian Government from $11.2 million in 2015 to $7.3 million in 2016.

During the 2016 Federal Election campaign, SARRAH developed an Election Platform which was sent to the major parties, minor parties and independent parliamentarians, asking them where they stand on health care in the bush. The responses were published on SARRAH's website.

During 2016–17 SARRAH will continue to focus on organisational priorities such as engaging with our membership base and diversifying our income sources.

Rod Wellington
Chief Executive Officer

SARRAH STRATEGIC DIRECTION AND ACHIEVEMENTS

Overview

The SARRAH Strategic Plan 2013–16 identified three domains of focus: Stakeholders, Internal Business Practices; and People, Learning and Development. Goals were set within each domain to enable SARRAH to achieve its vision:

It is our VISION that SARRAH is the voice for rural and remote allied health, influencing health reform to improve allied health services and providing support to Allied Health Professionals in rural and remote areas.

The Strategic Plan has guided SARRAH's activities and priorities over the three year period and during 2015–16, SARRAH made significant progress towards the achievement of many identified goals.

Towards the end of 2015–16, the SARRAH Board reviewed and endorsed the SARRAH 2016–19 Strategic Plan. The revised strategic plan will continue to focus on Organisation Viability, Advocacy and Public Policy as priorities for SARRAH in 2016-17.

Stakeholders

GOAL ONE: MEMBERS

SARRAH increases the number of members as well as those that actively participate in the organisation.

Achievements in 2015–16:

- SARRAH's corporate membership program continued in 2015–16 with a major recruitment drive aimed at broadening the base of SARRAH membership. As at June 2016, SARRAH had 25 corporate members. Through corporate memberships, SARRAH engages with more AHPs to improve allied health services in rural and remote areas.
- SARRAH streamlined processes to join and renew individual membership online. This has resulted in increased retention of members during 2015–16.
- Engagement with members and other people interested in rural and remote allied health has been achieved using social media platforms during 2015–16. SARRAH's Facebook content reached an audience of 4,704 people and SARRAH content was displayed over 33,000 times during June 2016.

SARRAH STRATEGIC DIRECTION AND ACHIEVEMENTS

GOAL TWO: HEALTH REFORMS

SARRAH continues as a leader to advocate at all levels of Government for reforms of health services, to improve health outcomes in rural and remote Australia.

Achievements in 2015–16:

- SARRAH continued to actively influence rural and remote health policy during 2015–16. Significant health policy advocacy activities included the House of Representatives Standing Committee on Health Inquiry into Chronic Disease Prevention and Management in Primary Care, the MBS Review Taskforce and the Primary Health Care Advisory Group.
- Overall, SARRAH provided submissions to nine consultation processes, developed three position papers, and participated in a large number of workshops, committees and consultation forums.
- SARRAH auspiced research projects that demonstrated the contribution of allied health services to improved health outcomes including:
  - The impact of allied health professionals in improving outcomes and reducing the cost of treating diabetes, osteoarthritis and stroke, prepared by Novartis Pharmaceuticals Australia, November 2015
  - Addressing diabetes-related foot disease in Indigenous NSW, by Virginia DeCourcy, March 2016.

GOAL THREE: WORKFORCE

SARRAH represents a workforce that is essential to addressing health inequality for residents of rural and remote communities.

Achievements in 2015–16:

- SARRAH represents 27 professions across all states and territories with approximately 75% living or operating in rural and remote regions of Australia.
- SARRAH members contribute to improving health and wellbeing for rural and remote Australians. This is achieved through participating in meetings with politicians, policy makers and other sector stakeholders, and representing SARRAH on committees and working groups.
- At the SARRAH Summit held from 11–14 October 2015, 17 SARRAH members met with representatives of the Department of Health, the Minister for Rural Health, the Shadow Health Minister, the Leader of the Australian Greens, and key independent parliamentarians. SARRAH representatives provided a grass roots perspective of the issues facing rural and remote communities.

National Press Club Address: Hidden Harms: How concealed budget cuts are killing Australia's health sector

Rod Wellington joined Michael Moore, CEO of the Public Health Association of Australia and Sheila McHale, CEO of the Palmerston Association on the 10th of November 2015 as part of a coalition of over 20 peak and non-government organisations from the health and community sector that called on the Australian Government to scrap plans to cut nearly $800M in funding to key health initiatives over four financial years.

At the address Rod Wellington said, "Projects and initiatives targeting rural and remote Australians are one of the areas that will be hit hard by these cuts. Essential services working to Close the Gap in health outcomes for indigenous Australians, managing vital responses to communicable diseases; and preventing and managing chronic diseases around the country have an uncertain future. The peak bodies that represent these services and work to improve health policy for rural and remote Australia are in the same position. Obviously this is of great concern to all the services and organisations potentially affected".

Internal business practices

GOAL FOUR: CORPORATE GOVERNANCE

SARRAH maintains mechanisms to support accountable and transparent governance procedures including planning, financial management and reporting.

Achievements in 2015–16:

- The SARRAH Board, Advisory Committee, sub-committees and working groups, received efficient secretariat support throughout 2015–16.
- SARRAH corporate governance processes were maintained at a high standard throughout 2015–16 overseen by the SARRAH Audit and Risk Committee and the SARRAH Board.

SARRAH STRATEGIC DIRECTION AND ACHIEVEMENTS

GOAL FIVE: PROJECTS AND PROGRAMS

SARRAH maintains efficient administrative systems to effectively manage projects and programs.

Achievements in 2015–16:

- SARRAH continued administering on behalf of the Commonwealth Government Department of Health the allied health component of the Nursing and Allied Health Scholarship and Support Scheme (NAHSSS), exceeding program targets and maximising the availability of scholarships for rural and remote AHPs.
- SARRAH also completed an internal review of NAHSSS scholarships to identify effectiveness in addressing workforce shortages.

People, learning and development

GOAL SIX: HUMAN RESOURCES

SARRAH recruits, fosters and values highly trained staff.

Achievements in 2015–16:

- During 2015–16, SARRAH responded to the reduction in government funding for program administration with reduced staffing levels. The remaining staff maintained a high level of efficiency throughout the year in the face of a higher overall workload.

GOAL SEVEN: INFORMATION AND KNOWLEDGE MANAGEMENT

SARRAH maintains effective information technology and knowledge management systems to improve performance, retain corporate knowledge, and provide a resource for all stakeholders.

Achievements in 2015–16:

- SARRAH revised its records management policy and administrative guidelines which have been used to reduce the amount of onsite storage of files. This involved assigning disposal dates to records so they can be destroyed once they no longer hold any business value.

SARRAH MEMBERSHIP

SARRAH supports and enables members to contribute to improved health outcomes through advocacy and policy development. Members join jurisdiction and discipline based networks which are managed by volunteer Network Coordinators. The Network Coordinators also sit on the SARRAH Advisory Committee and provide input into SARRAH policy priorities and strategic direction, and are a two way conduit of information and advice between members and the SARRAH Board of Directors.

Members also benefit from the following services:

- receiving updates and information about development and support opportunities through newsletters, social media, website updates, directly over the phone and by email
- contributing to the rural and remote health policy discussion by being able to provide input to position papers, and submissions presented to local, state and federal governments
- facilitating collaborative opportunities to overcome geographic isolation
- participating in state-based member meetings and discussion groups
- providing updates on developments with respect to current rural health issues and research
- receiving a subscription to the *Australian Journal of Rural Health* and SARRAH publications
- participating in the biennial SARRAH National Conference and SARRAH Summit.

Engaging with SARRAH's membership base is an ongoing project. The organisation is constantly seeking new and innovative ideas and platforms on which to engage current members, and encourage new members to join. This is an area SARRAH plans to continue developing in 2016–17.

CORPORATE MEMBERS

SARRAH's corporate membership program recognises the value of partnering with the Australian healthcare sector as a key enabler for improving the health and wellbeing of people residing in rural and remote Australia. SARRAH would like to thank the organisations who joined as corporate members in 2015–16.

SARRAH will continue to invite organisations who share our goals in giving a voice to AHPs to shape health policy and programs that address the needs of people in the bush and running programs that enhance the accessibility and performance of the Australian healthcare sector. Organisations are invited to arrange a meeting with SARRAH CEO, Rod Wellington, to discuss how we can work together.

Universities

Primary Health Networks

phn CENTRAL QUEENSLAND, WIDE BAY, SUNSHINE COAST
An Australian Government Initiative

phn NORTHERN TERRITORY
An Australian Government Initiative

phn WESTERN QUEENSLAND
An Australian Government Initiative

Health Service Organisations

aspenmedical

marathon health

Royal Flying Doctor Service

Senator Fiona Nash speaks about the work of SARRAH

When asked a question without notice by Senator Zhenya Wang about the work of SARRAH, Senator Fiona Nash, Minister for Rural Health responded,

"I am a great supporter of the work of SARRAH. Indeed, just this week, I was very privileged to be at a dinner that they were holding for one of the young people who has been a beneficiary of one of their internal scholarships. There is absolutely no doubt that allied health is incredibly important when it comes to health service delivery in rural and regional areas, and indeed it was a discussion that I was having with them just a couple of days ago.

We need to make sure that the taxpayers' dollars that we are responsible for are effectively spent and efficiently spent. It certainly does not detract from the work that SARRAH does. Indeed, as I have said, they prosecute the case very well for allied health services across our rural and regional communities."

SARRAH will continue to prosecute the case for increased access to allied health services across our rural and regional communities.

COMMUNICATION AND ENGAGEMENT

SARRAH has implemented a range of communication strategies to raise its profile, and engage with members and sector stakeholders throughout 2015–16.

SARRAH's communication and engagement activities focus on overcoming issues facing rural and remote AHPs (such as workforce shortages, high workloads, travel and limited internet access). In 2015–16, SARRAH:

- engaged with politicians and federal government representatives during the SARRAH Summit held over four days in October 2015
- distributed eight media releases to news outlets and received coverage on all occasions
- published four media articles in a range of print publications including *Partyline*, Geraldton Newspapers and the *Macleay Argus*
- conducted nine media interviews, two press conferences and one media appearance at the National Press Club of Australia which were broadcast over several television and radio networks
- published three publications, 12 e-bulletins, eight special broadcasts and six board meeting communiques online through email and the SARRAH website
- expanded its social media presence from an audience of 1,294 likes and reach of 1,373 in June 2015 to a unique audience for SARRAH content reaching 4,704 people, culminating in SARRAH content being displayed over 33,000 times during June 2016
- prepared nine submissions responding to federal health policy discussions including the Medicare Taskforce reviewing the Medicare Benefits Schedule and the Senate Community Affairs Reference Committee Inquiry into the Future of Australia's Aged Care Sector Workforce
- prepared promotional material and resources for the SARRAH Summit, meetings with parliamentarians, health organisations and members
- managed advertising campaigns to publicise scholarship applications for the Nursing and Allied Health Scholarship Support Scheme (NAHSSS).

FUTURE STRATEGIC DIRECTION

It is widely acknowledged that Australians who live in rural and remote areas experience poorer health than those who live in capital cities or major towns. Yet as Governments pursue health reforms, the needs of rural and remote Australians are rarely taken into account. The need for a strong rural and remote voice in national health policy remains as strong as ever.

In 2016 and beyond, SARRAH must continue to be a bridge between grassroots AHPs and national policy makers and parliamentarians. Building effective ways to engage and support our members to contribute to health policy will be a priority action area for SARRAH during 2016–17. At the same time, SARRAH will maintain its existing high level of influence in the national political arena.

SARRAH will continue to improve its long term viability by building a strong individual and corporate membership base. Our members will be key contributors to project and policy development processes and will receive value for money through practical hands-on support along with other benefits. Combined with pursuing projects at the local, state and federal levels, SARRAH will continue to develop more diverse income streams and ensure that the organisation is sustainable into the future.

Research into the real economic benefits of increasing access to allied health services in rural and remote Australia will strengthen the case for properly supporting and building the allied health workforce. SARRAH will continue to seek funding to conduct research into the economic benefits of early allied health treatment of chronic diseases to improve the health of people living in the bush. SARRAH will share the outcomes of the research with parliamentarians to push for health reform in this policy area.

According to the Department of Health Review of Australian Government Health Workforce Programs released in May 2013, AHPs are more likely to continue working in rural and remote communities when provided an economic incentive, along with peer support. SARRAH will work with its corporate members to develop program proposals structured around incentives and support and seek funding from a variety of sources to implement such programs.

04 PROGRAMS AND PROJECTS

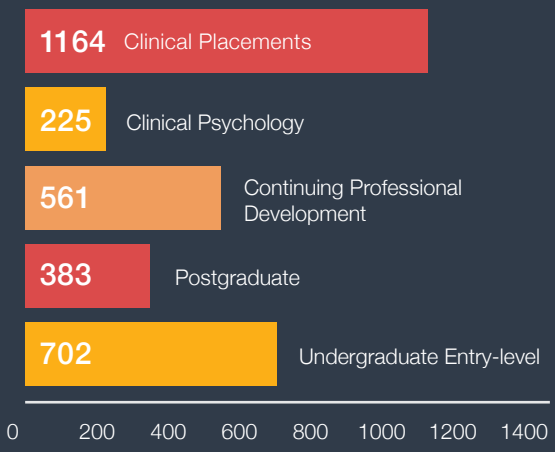
One of the great opportunities of corporate membership with SARRAH is the ability to collaborate on developing proposals that bring flow-on benefits to the organisations themselves and more importantly, to the people who reside in rural and remote communities. This includes collaborating on both research proposals and tangible on the ground programs that support individuals and communities.

NURSING AND ALLIED HEALTH SCHOLARSHIP SUPPORT SCHEME INFOGRAPHICS

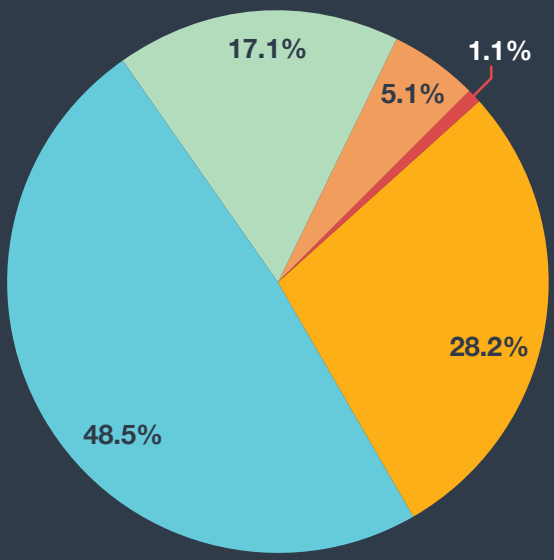
$7.3 Million
total scholarship funding committed to supporting scholars in 2015-16

34%
cut to NAHSSS funding a result of Federal budget cuts

Demand for NAHSSS scholarships in 2015-16



Distribution of scholarships awarded by ASGC classification which determines the rurality of applicants



- **ASGC-RA 5** represents **0.90%** of population
- **ASGC-RA 4** represents **1.40%** of the population
- **ASGC-RA 3** represents **8.80%** of the population
- **ASGC-RA 2** represents **18.2%** of the population
- **ASGC-RA 1** represents **70.0%** of the population

884
current scholars over three scholarship streams as at 30 June 2016

548
scholarships awarded to eligible applicants in 2015-16

326
scholarship places lost as a result of funding cuts in 2015-16

3,035
scholarship applications received from eligible scholars in 2015-16

NURSING AND ALLIED HEALTH SCHOLARSHIP AND SUPPORT SCHEME

During 2015–16, SARRAH continued to support the rural and remote allied health workforce by delivering the NAHSSS, funded by the Australian Government Department of Health (DoH). Over the lifetime of the national program, scholarships have supported AHPs and students to train in rural and remote areas of need.

The objectives of the NAHSSS are to:

- Build the health workforce and facilitate the entry of job seekers and young people interested in pursuing a career in allied health or nursing professions
- Encourage people to pursue a career in health care professions and geographic areas where there are workforce shortages
- Facilitate the continuing professional development of nurses and allied health professionals.

Allied health scholarships were available in the following streams:

- **Undergraduate** scholarships support students currently enrolled or intending to enrol in an accredited allied health discipline at an Australia-based university
- **Postgraduate** scholarships support qualified AHPs who deliver services in rural and remote areas of Australia and are studying or seeking to study an accredited postgraduate qualification at a recognised university located in Australia
- **Clinical Psychology** scholarships support psychology graduates seeking registration with the Psychology Board of Australia to become endorsed clinical psychologists. Only students studying Australian Psychology Accreditation Council (APAC) accredited clinical psychology courses are eligible to receive the scholarship
- **Continuing Professional Development** scholarships support allied health professionals to maintain and improve their skills and knowledge in their clinical areas of practice by providing financial assistance to complete paid professional development activities
- **Clinical Placement** scholarships support allied health students undertaking rural and remote clinical placements; who in turn choose to practise and contribute to a long term increase in rural and remote allied health workforce capacity.

The scholarships offered in the 2015–16 financial year were targeted to specific areas of practice in primary care, aged care, mental health and indigenous health services. Rurality was among several ranking tools used to create an order of merit, with the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) used to determine the rurality status of the applicants.

NAHSSS commenced in July 2010. Since its inception, over 4,500 scholarships have been awarded to allied health students and practising AHPs. As at 30 June 2016 the program had a total of 884 ongoing scholars across the Undergraduate, Postgraduate and Clinical Psychology streams. Clinical Placement and Continuing Professional Development streams concluded at the end of the 2015-16 financial year.

In the 2015–16 Federal Budget, the Australian Government committed to deliver health workforce scholarships through a single agency for the 2017 academic year. At the time of publication, SARRAH is continuing to administer scholarships to existing recipients of the allied health component of the Nursing and Allied Health Scholarship and Support Scheme.

Figure 2: Applications received and scholarships awarded 2011-16

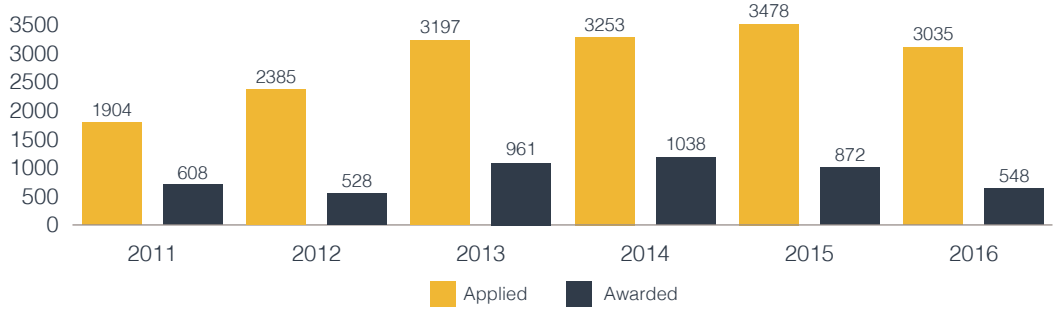


Table 1: Applications received and scholarships awarded in 2015 and 2016 academic years

	2015			2016		
	Applied	Awarded	Success rate %	Applied	Awarded	Success rate %
Clinical Placements	1454	259	18	1164	96	8
Clinical Psychology	271	75	28	225	44	20
CPD	686	169	25	561	108	19
Postgraduate	402	203	50	383	193	50
Undergraduate	665	166	25	702	107	15
Total	3478	872	25	3035	548	18

Table 2: Scholarship recipients at 30 June 2016

Scholarship program	Total
Clinical Psychology	105
Postgraduate	387
Undergraduate	392
Total Scholars as at 30 June 2016	884
Note: All Clinical Placements and CPD Scholarship payments have been completed as of 30 June 2016.	

Aboriginal and Torres Strait Islander applicants

SARRAH has continued to encourage AHPs and students who identify as being from an Aboriginal or Torres Strait Islander (ATSI) background to apply for the NAHSSS scholarships and ATSI applicants have been given priority when awarding scholarships. The number of applications received from people identifying and being from an ATSI background was 51 across five scholarship streams in 2015–16.

NURSING AND ALLIED HEALTH SCHOLARSHIP AND SUPPORT SCHEME

NAHSSS Clinical Placement Scholarship

SARRAH has administered Clinical Placement Scholarships since 2008 and these scholarships are essential in helping allied health students experience the opportunities and challenges of rural and remote practice. Students receive a Clinical Placement Scholarship to support them to undertake a clinical placement in an eligible allied health profession. The NAHSSS Clinical Placement Scholarships provides up to $11,000 for placements located in ASGC-RA areas 2–5 for a maximum duration of 6 weeks.

Figure 3: Placement completed by ASGC-RA - 2015 (full year) and 2016 (January to June)

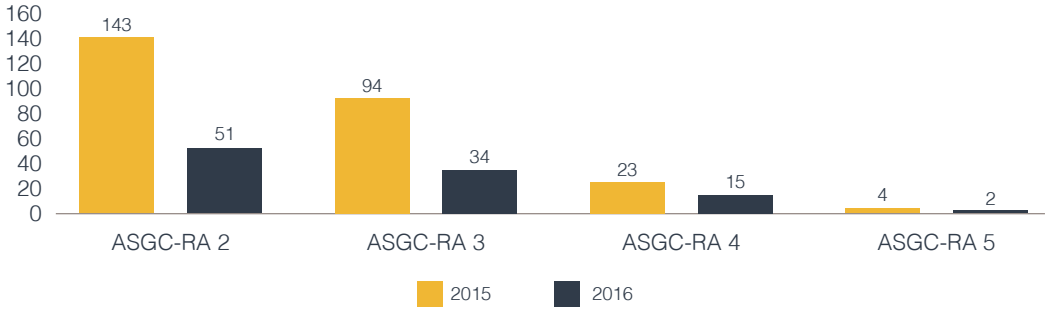


Table 3: Scholarship recipients at 30 June 2016

	ASGC-RA 2	ASGC-RA 3	ASGC-RA 4	ASGC-RA 5	Total
2015	143	94	23	4	264
2016	51	34	15	2	102
Note: Some scholars have undertaken split placements accounting for a higher number of overall recipients.					

Figure 4: Placement completed by number of weeks - 2015 (full year) and 2016 (January to June)

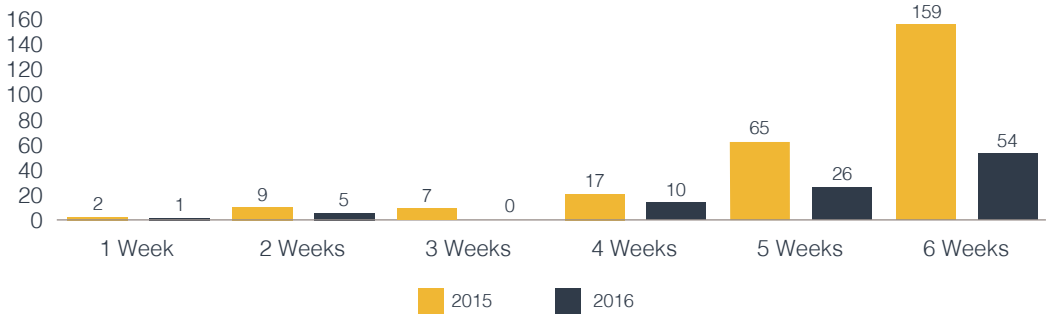
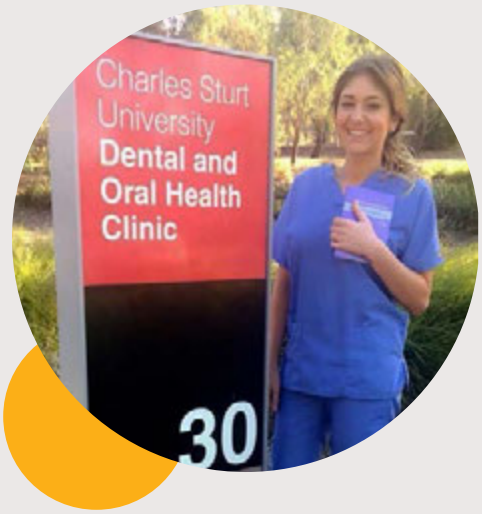


Table 4: Placement completed by number of weeks - 2015 (full year) and 2016 (January to June)

	1 Week	2 Weeks	3 Weeks	4 Weeks	5 Weeks	6 Weeks
2015	2	9	7	17	65	159
2016	1	5	0	10	26	54

SCHOLAR STORY BY KARLI JAMES



The clinical placement I have undertaken with the support of SARRAH/NAHSSS Clinical Placement Scholarship was at the Charles Sturt University Dental and Oral Health Clinic.

I feel that the entire placement was hugely successful and has highlighted the importance of following this career path. I have been determined to study tertiary education for about 6 years now, since becoming a Dental Nurse in 2010. Last year, our degree was heavily focused on content, biomedical science, clinical skills, psychology. Whilst still achieving reasonable grades - keeping focused on the bigger picture of this degree was difficult.

During second year, we have again had a heavy content load, but this has been combined with the clinical placements, putting everything we have learnt into practice. It has given us an opportunity to show our skills, knowledge and benefit the patient. When we first started seeing our own patients, it was one of the most rewarding experiences I have ever had.

I was able to confidently evaluate and understand my patients concerns and utilising what we have discussed in class to formulate treatment plans and provide advice specific for each patient. This was all done under the supervision of our wonderful tutors at the Wagga Wagga clinic, who I cannot congratulate enough on their skills and support.

> *"The placement itself went so quickly, whilst some of the girls I was sharing accommodation with suffered tremendously with anxiety, loss of appetite and home-sickness, I could not get enough of it. I didn't want placement to end! There were a few incredibly long days where we finished around 8pm, however I still maintained focus - whether I was running on adrenaline, the entire experience was so fulfilling.*

Having accommodation which was close to the clinic, close to the CBD and safe and secure really made everything even easier. Other students were complaining about noisy accommodation, with disruptive tenants and fellow students, no internet, long distances to the clinic. I feel so fortunate that, because of this clinical scholarship, I did not have the stress of these things.

I came home each night and could relax and study in bed or reflect on the day with my fellow students. I am saddened to think that I won't always be able to afford this accommodation for my upcoming scholarships, but I truly appreciate having the 4 week approval as it is supporting me through a very special and important part of my life and career.

NURSING AND ALLIED HEALTH SCHOLARSHIP AND SUPPORT SCHEME

NAHSSS Clinical Psychology Scholarship

SARRAH has administered the Clinical Psychology Scholarships since 2010. The scholarships help increase the clinical psychology workforce in rural and remote areas, and provide support for students who are studying to obtain qualifications required to become endorsed as Clinical Psychologists. Scholars receive up to $30,000 for full time study over two years to help meet their study and living expenses.

Figure 5: Clinical Psychology Scholarships awarded by home ASGC-RA, 2015-16

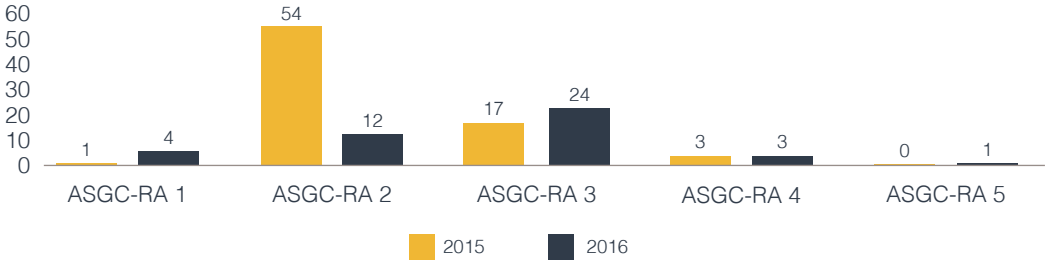


Table 5: Clinical Psychology Scholarships awarded by home ASGC-RA, 2015-16

	ASGC-RA 1	ASGC-RA 2	ASGC-RA 3	ASGC-RA 4	ASGC-RA 5	Total
2015	1	54	17	3	0	75
2016	4	12	24	3	1	44
Note: Scholarships awarded to ASGC-RA 1 are from ATSI background						

NAHSSS Continuing Professional Development Scholarship

SARRAH has administered the Continuing Professional Development (CPD) Scholarships since 2003 under various schemes. CPD scholarships provide AHPs living and working in rural and remote areas with support to undertake continuing professional development activities such as attending conferences, short courses, non award post graduate courses and clinical placements. The NAHSSS CPD scholarships are open to AHPs practising across Australia. The rural status of the applicant was used as a ranking tool in 2015–16 as applications for the scholarship wer oversubscribed. Successful applicants received up to $1,500 towards course or registration fees and travel and accommodation costs.

Figure 6: Continuing Professional Development Scholarships awarded by home ASGC-RA, 2015-16

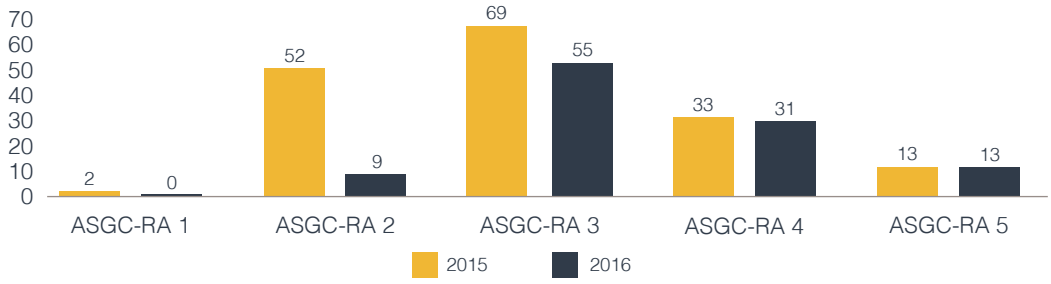


Table 6: Continuing Professional Development Scholarships awarded by home ASGC-RA, 2015-16

	ASGC-RA 1	ASGC-RA 2	ASGC-RA 3	ASGC-RA 4	ASGC-RA 5	Total
2015	2	52	69	33	13	169
2016	0	9	55	31	13	108
Note: Scholarships awarded to ASGC-RA 1 are from ATSI background						

Figure 7: Scholarships awarded by activity type, 2015-16

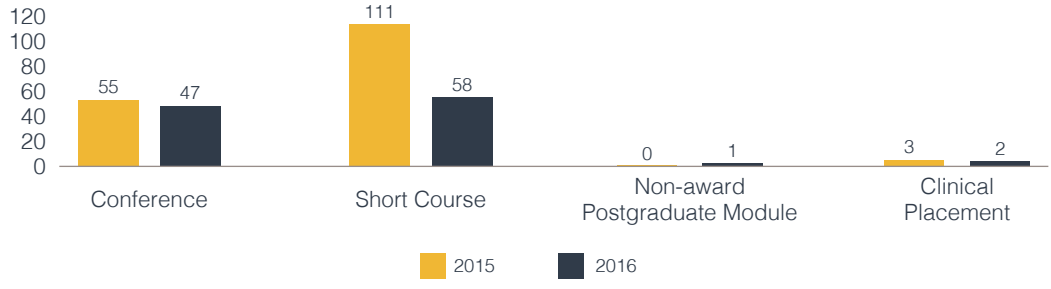


Table 7: Scholarships awarded by activity type, 2015-16

	Conference	Short Course	Non-award Postgraduate Module	Clinical Placement	Total
2015	55	111	0	3	169
2016	47	58	1	2	108

NURSING AND ALLIED HEALTH SCHOLARSHIP AND SUPPORT SCHEME

NAHSSS Postgraduate Scholarship

SARRAH has administered the Postgraduate Scholarships to AHPs since 2003 under various schemes. The scholarships provide funding to assist AHPs from rural and remote areas to undertake postgraduate study and improve their skills and ability to provide services to rural and remote communities. Similar to other scholarship streams, applications for Postgraduate Scholarships were oversubscribed in 2015–16. To create the order of merit for awarding the scholarships, rural status was used as a ranking tool. Scholars receive funding to assist with course fees and living expenses, with the amount of funding varying for different levels of qualifications or study programs.

Figure 8: Postgraduate Scholarships awarded by ASGC-RA, 2015-16

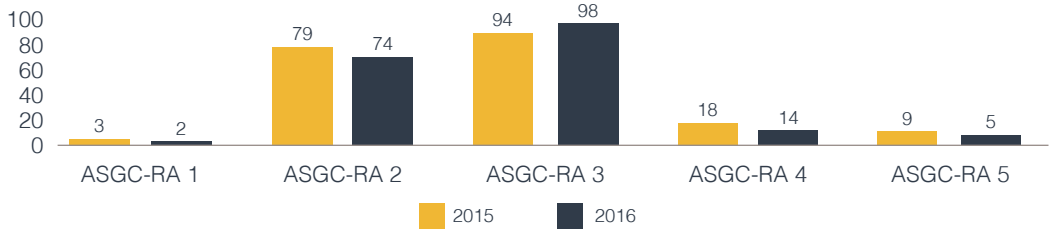


Table 8: Postgraduate Scholarships awarded by ASGC-RA, 2015-16

	ASGC-RA 1	ASGC-RA 2	ASGC-RA 3	ASGC-RA 4	ASGC-RA 5	Total
2015	3	79	94	18	9	203
2016	2	74	98	14	5	193
Note: Scholarships awarded to ASGC-RA 1 are from ATSI background						

Figure 9: Postgraduate Scholarships awarded by activity type, 2015-16

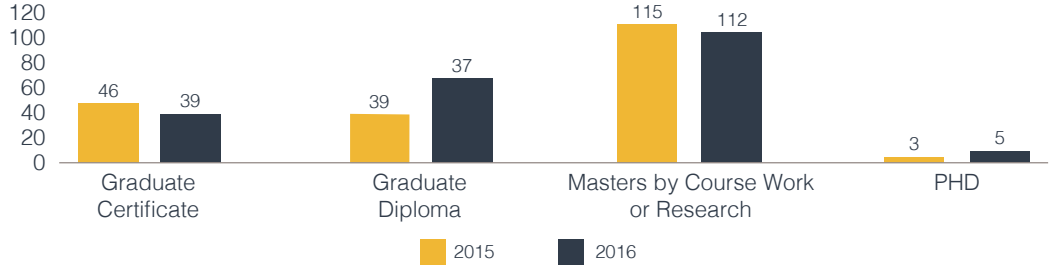


Table 9: Postgraduate Scholarships awarded by activity type, 2015-16

	Graduate Certificate	Graduate Diploma	Masters by Course Work / Research	PhD	Total
2015	46	39	115	3	203
2016	39	37	112	5	193

NAHSSS Undergraduate (Entry-level) Scholarship

SARRAH has administered the Undergraduate Scholarships since 2005 under various schemes. The scholarships are targeted at students from a rural and remote background seeking to become AHPs through an eligible allied health course. Students receive scholarship funding of up to $30,000 over three years of study. The undergraduate scholarships are targeted to students from ASGC-RA areas 2 - 5.

Figure 10: Undergraduate (entry-level) Scholarships awarded by ASGC-RA, 2015-16

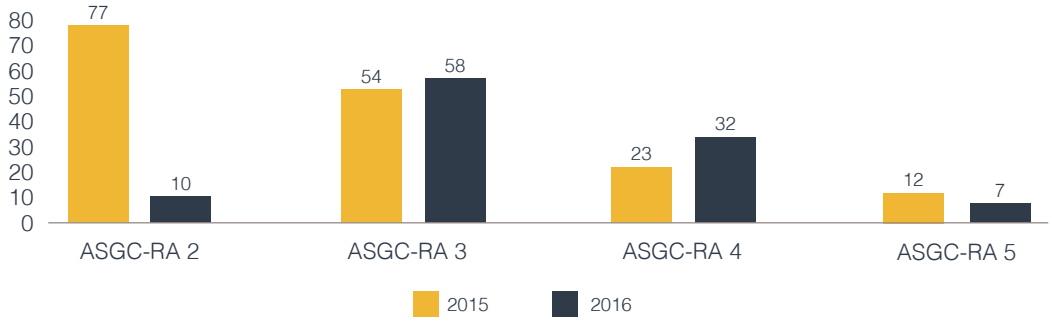


Table 10: Undergraduate (entry-level) Scholarships awarded by ASGC-RA, 2015-16

	ASGC-RA 2	ASGC-RA 3	ASGC-RA 4	ASGC-RA 5	Total
2015	77	54	23	12	166
2016	10	58	32	7	107
Note: Scholarships awarded to ASGC-RA 1 are from ATSI background					

SCHOLAR STORY BY NATALIE MCLENNAN

My name is Natalie McLennan, and I have just completed my Bachelor in Speech Pathology (Hons.) at the University of Queensland, thanks to the financial support of the SARRAH Nursing and Allied Health Scholarship Support Scheme. I grew up in Emerald (Central Queensland), and in order to study my chosen degree, I was required to relocate to the city. I had never even lived in town before, so this change was quite significant! Of greater significance to my family however was the expense that my decision would bring to them.

" Being straight out of high school, I knew my meagre savings would barely scratch the surface. With peace of mind from the generous financial contribution of the NAHSSS, I used the funds to offset my accommodation costs and make student contributions towards my required university fees, and pay for university-related resources such as textbooks, clinic clothes and therapy resources.

In addition to full time study, I also participated in UQ's Rural Health club, TROHPIQ (Towards Rural and Outback Health Professionals in Queensland) for three of my four years of study. I held the position of Speech Pathology Representative for two years, which saw me advertise the club and its worthwhile activities to the speech pathology cohorts at UQ and consult with organisations such as Deadly Ears and BUSHKids.

In collaboration with the other allied health representatives, we organised several events aiming to equip, train and prepare students for rural placements and working in rural areas. These included an allied health information evening where we had several guest speakers, and a weekend inter-disciplinary team health challenge (BRAHN). Other events I attended include TROHPIQ's annual Cherbourg trip where we run health promotion activities at a local football game, the HealthFusion Health Care Team Challenge and manning the TROHPIQ stall at market days.

Unfortunately the most 'rural' experience I got on my university placements was my six week placement in Toowoomba, however this was a great experience, and I used my opportunities in city placements to see how my role in such settings may be applied or adapted to successful and effective practice in rural settings. Coupled with my own experience of growing up in Central Queensland and visiting more remote locations such as Cherbourg and Goomeri, I believe this was a valuable part of my training, and something that I am sure to remember and apply next year in my speech pathology position with the Department of Education and Training in Biloela (Central QLD) and indeed, throughout my working career.

The most important thing that I have learnt through my experience in rural areas is that your time there is as you make it. This applies to working as a professional and receiving professional accomplishment from your job, as well as integrating socially in the community. If you go in with a 'give it a go' attitude, and willingness to problem solve and be innovative, you will get so much more out of the professional and social opportunities that it presents.

THE 2015 SARRAH SUMMIT

The SARRAH Summit is a key event in SARRAH's calendar, bringing members together in Canberra to advocate directly to parliamentarians and policy makers for improved allied health services for rural and remote Australia.

The 2015 Summit was held from 11–14 October 2015 with 17 delegates attending from across Australia and representing a range of allied health professions. Members were brought face-to-face with key parliamentarians to highlight the situation facing allied health services in rural and remote Australia.

At the summit, delegates met with Peter Tucker, Chief of Staff to Andrew Wilkie MP, Senator Nick Xenophon, Senator Jacqui Lambie, Senator John Madigan, Senator Zhenwa Wang, Senator Richard Di Natale, The Hon Catherine King MP and Stephen Jones MP.

Case studies presented by SARRAH delegates highlighted the need for greater funding of allied health services in the bush. In some meetings, delegates were moved by the support provided by some politicians, especially in relation to real effects of under-resourcing allied health services in the bush. The delegates also participated in a series of workshops to shape the future direction of SARRAH and develop effective key messages which were shared with peers and parliamentarians.

Other activities over the summit included the SARRAH Annual General Meeting and Kate Scanlon Award Dinner. The Kate Scanlon award was created in 2012 in memory of Kate Scanlon who was a NAHSSS recipient. In November 2011 Kate Scanlon tragically lost her life in India when the train she was travelling in from Kolkata to the northern town of Dehradun, caught fire. Kate was going there to run a first aid course and physiotherapy clinic along with other students. Twenty-one year old Kate from Tasmania was studying physiotherapy at Monash University and had been receiving the NAHSSS Undergraduate Scholarship since 2010.

The Kate Scanlon Award provides Tasmanian scholarship recipients with an opportunity to pursue a project or activity that will improve allied health services for Tasmanians. In 2015 the Award was presented to Claire Johns by Senator Fiona Nash, Minister of Rural Health. Claire is a 4th year chiropractic student who grew up in Whitemore in Tasmania and moved to Melbourne to study at Royal Melbourne Institute of Technology. Claire plans to use her $5,000 prize to help the not-for-profit organisation, Hands-On-Health Australia and revitalise the Spinosaurus program and develop it further. The program serves to educate both rural and indigenous primary school aged children about both spinal and general health.

THE IMPACT OF ALLIED HEALTH PROFESSIONALS IN IMPROVING OUTCOMES AND REDUCING THE COST OF TREATING DIABETES OSTEOARTHRITIS AND STROKE REPORT

In response to a call for the allied health sector to demonstrate economic evidence of effectiveness in clinical treatment, SARRAH through Novartis Pharmaceuticals Australia completed an economic analysis of the impact of allied health professionals (AHPs) in improving health outcomes and reducing the cost of treating three chronic diseases: diabetes, osteoarthritis and stroke.

The report titled *The Impact of allied health professionals in improving outcomes and reducing the cost of treating diabetes, osteoarthritis and stroke* released in 2015 reviewed all available evidence and evaluated the economic impact of allied services provided to Australians with three common health conditions – stroke, diabetes and osteoarthritis.

> *"The report identifies potential annual savings of $175 million to the Australian healthcare budget from the implementation of eight allied health interventions.*

The report also found that a significant number of negative health outcomes such as lower limb amputation and kidney failure were reduced when patients are treated by AHPs. The report is important as it identifies that there needs to be further research to build a stronger economic evidence base to identify the scope of savings to the healthcare system. It also highlights that greater access to allied health services are required in rural and remote communities to proactively address common chronic health conditions.

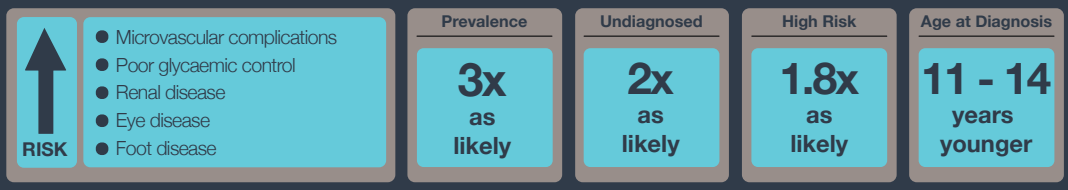
The report was launched at Parliament House on 2 December 2015 by SARRAH CEO Rod Wellinton. Members of Parliament, Senators and their representatives attended the launch. It is anticipated that the report will lead to follow-up research on the economic benefits of allied health interventions and has called on the government in 2015–16 to provide funding to undertake a robust economic evaluation of allied health interventions in rural and remote communities.

The report was prepared for SARRAH by Novartis Pharmaceuticals Australia through a pro bono arrangement.

ADDRESSING DIABETES-RELATED FOOT DISEASE IN INDIGENOUS NSW

SARRAH was funded by the New South Wales Ministry of Health in early 2016 to investigate the prevalence of diabetes related foot disease (DRFD) and workforce strategies that could address DRFD. The report looked at the prevalence of diabetes, and diabetes-related foot disease in the Indigenous population, and reviewed the evidence of successful strategies, including workforce approaches, in addressing diabetes-related foot disease. DRFD is disproportionately prevalent within Indigenous populations. Compared with non-Indigenous patients, Indigenous patients are:

- admitted to hospital for DRFD more often
- have more amputations
- suffer more co-morbidities
- require longer length of stay in hospital
- experience DRFD at a younger age.



The report identified that best practice for the treatment of DRFD is a multidisciplinary team. This indicates that podiatrists and AHPs, although central to addressing this problem, are not the only health practitioners relevant to addressing this problem.

Another key finding in the report was that integrating services and programs with existing local health care providers, especially Aboriginal Community Controlled Health Organisations (ACCHOs), is paramount to the delivery of successful healthcare programs for Indigenous people. Health programs focused on Indigenous health concerns are successful with Indigenous leadership, and involve a high level of community consultation and participation.

The report also found while there have been efforts made to address the problem of DRFD within the Indigenous population, approaches have been ad hoc and evaluation of their impact on health outcomes has been scant. There is an opportunity for future research in this area, especially the effect of such programs on clinical outcomes such as ulceration and amputation rates.

05 FINANCIAL MANAGEMENT

SARRAH advocates on behalf of its individual and corporate members by meeting with parliamentarians at the local, state and federal levels to discuss issues of importance to its members. This has resulted in the appointment of a chief allied health officer and raising the profile of rural and remote allied health through the establishment of a parliamentary friendship group.

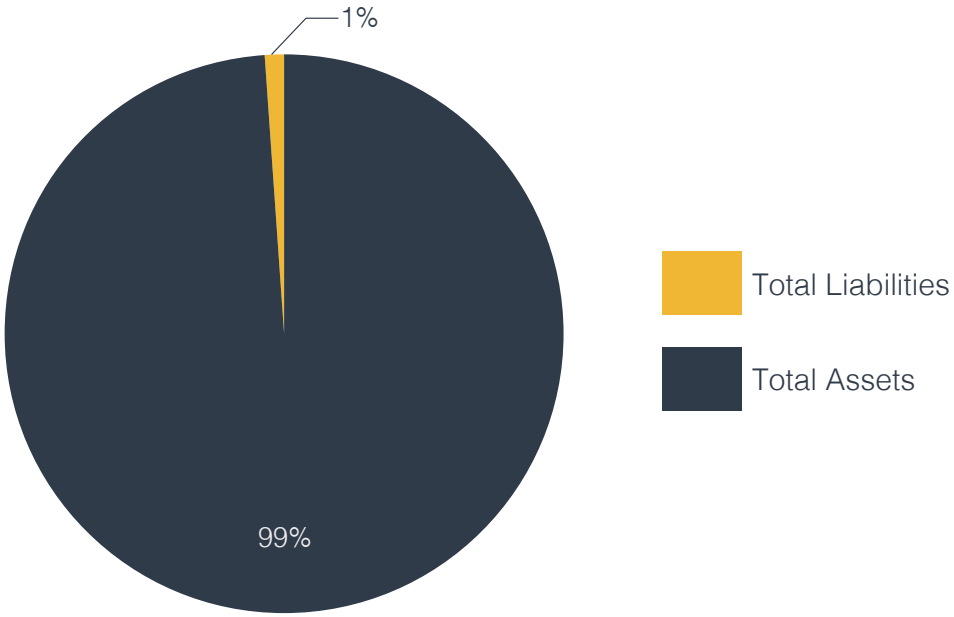
STATEMENT OF FINANCIAL POSITION

Assets and Liabilities as at 30 June 2016

Assets	2016 ($)	2015 ($)
Current Assets	$14,895,231	$15,787,745
Non-Current Assets	$69,465	$91,002
Total Assets	**$14,964,696**	**$15,878,747**

Liabilities	2016 ($)	2015 ($)
Current Liabilities	$118,355	$250,772
Non-Current Liabilities	$15,981	$21,869
Total Liabilities	**$134,336**	**$272,641**
Net Assets	**$14,830,360**	**$15,606,106**

SARRAH had a cash surplus of $14.83 million of which approximately 97% is committed to scholarships that have been granted and for which future payments are required.



STATEMENT OF FINANCIAL POSITION

Revenue to 30 June 2016

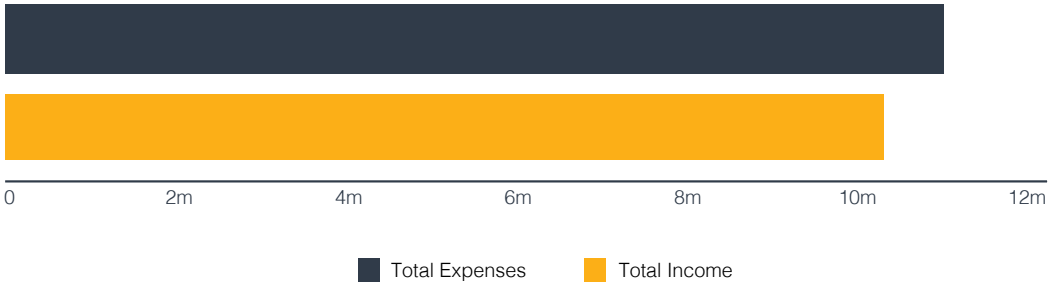
SARRAH received revenue of $10.2 million for 2015-16 and the following table represents actual results through to 30 June 2016.

Revenue	2016 ($)	2015 ($)
Department of Health Grants	$9,722,180	$11,401,264
Interest income	$147,406	$235,010
Membership fees	$130,635	$41,584
Conference income	-	$67,617
Other income	$232,384	$205,939
NRRSS income	-	$150,000
Mid North Coast Health income	-	$34,173
Total Revenue	**$10,232,605**	**$12,135,587**

Expenses to 30 June 2016

SARRAH's expenses were $11.0 million during 2015-16 and the table below presents actual results through to 30 June 2016.

Expenses	2016 ($)	2015 ($)
Employee provisions expense	$844,196	$1,168,090
Depreciation expense	$21,537	$23,365
Rental expense	$123,187	$102,032
Scholarship payments	$9,549,509	$11,051,878
Conference expenses	-	$28,462
Other expenses	$466,988	$475,293
Mid North Coast Health Expenses	$2,934	$27,384
Total Expenses	**$11,008,351**	**$12,876,504**



SERVICES FOR AUSTRALIAN RURAL AND REMOTE ALLIED HEALTH INCORPORATED (SARRAH)

ABN 92 088 913 517

FINANCIAL REPORT FOR THE YEAR ENDED 30 JUNE 2016

SERVICES FOR AUSTRALIAN RURAL AND REMOTE ALLIED HEAH INCORPORATED

ABN 92 088 913 517

STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME FOR THE YEAR ENDED 30 JUNE 2016

	Note	2016 $	2015 $
Revenue	2	10,232,605	12,135,587
Employee provisions expense	3	(844,196)	(1,168,090)
Depreciation expense		(21,537)	(23,365)
Rental expense	3	(123,187)	(102,032)
Scholarship payments	3	(9,549,509)	(11,051,878)
Conference expenses	3	-	(28,462)
Mid North Coast Health expenses		(2,934)	(27,384)
Other expenses	3	(466,988)	(475,293)
Net current year (deficit)		(775,746)	(740,917)
Other comprehensive income		-	-
Total comprehensive income for the year		(775,746)	(740,917)

The accompanying notes form part of these financial statements.

SERVICES FOR AUSTRALIAN RURAL AND REMOTE ALLIED HEAH INCORPORATED

ABN 92 088 913 517

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2016

	Note	2016 $	2015 $
ASSETS			
CURRENT ASSETS			
Cash and cash equivalents	5	14,872,357	15,669,665
Trade and other receivables	6	12,631	96,572
Other current assets	7	10,243	21,508
TOTAL CURRENT ASSETS		14,895,231	15,787,745
NON-CURRENT ASSETS			
Plant and equipment	8	69,465	91,002
TOTAL NON-CURRENT ASSETS		69,465	91,002
TOTAL ASSETS		14,964,696	15,878,747
LIABILITIES			
CURRENT LIABILITIES			
Trade and other payables	9	73,875	196,499
Provisions	10	40,203	49,996
Lease liability	11	4,277	4,277
TOTAL CURRENT LIABILITIES		118,355	250,772
NON-CURRENT LIABILITIES			
Provisions	10	10,279	11,890
Lease liability	11	5,702	9,979
TOTAL NON-CURRENT LIABILITIES		15,981	21,869
TOTAL LIABILITIES		134,336	272,641
NET ASSETS		14,830,360	15,606,106
EQUITY			
Retained surplus		14,830,360	15,606,106
TOTAL EQUITY		14,830,360	15,606,106

The accompanying notes form part of these financial statements.

SERVICES FOR AUSTRALIAN RURAL AND REMOTE ALLIED HEAH INCORPORATED

ABN 92 088 913 517

STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2016

	Retained Surplus $	Total $
Balance at 1 July 2014	16,347,023	16,347,023
Comprehensive income		
Net (deficit) for the year	(740,917)	(740,917)
Balance at 30 June 2015	15,606,106	15,606,106
Comprehensive income		
Net (deficit) for the year	(775,746)	(775,746)
Balance at 30 June 2016	14,830,360	14,830,360

The accompanying notes form part of these financial statements.

SERVICES FOR AUSTRALIAN RURAL AND REMOTE ALLIED HEAH INCORPORATED

ABN 92 088 913 517

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2016

	Note	2016 $	2015 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipts from government, members and customers		10,446,459	12,273,480
Interest received		147,406	235,010
Net GST (paid)		(197,300)	(346,360)
Payments to suppliers and employees		(11,189,596)	(12,949,722)
Net cash (used by) operating activities	16	(793,031)	(787,592)
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of plant and equipment		-	(17,213)
Net cash used in investing activities		-	(17,213)
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of borrowings		(4,277)	(4,277)
Net cash used in financing activities		(4,277)	(4,277)
Net (decrease) in cash held		(797,308)	(809,082)
Cash and cash equivalents at beginning of financial year		15,669,665	16,478,747
Cash and cash equivalents at end of financial year	5	14,872,357	15,669,665

The accompanying notes form part of these financial statements.

SERVICES FOR AUSTRALIAN RURAL & REMOTE ALLIED HEALTH INCORPORATED

ABN 92 088 913 517

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2016

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The financial statements were authorised for issue on 13 September 2016 by the members of the committee.

Basis of Preparation

Services for Australian Rural and Remote Allied Health Incorporated (SARRAH) applies Australian Accounting Standards – Reduced Disclosure Requirements as set out in AASB 1053: *Application of Tiers of Australian Accounting Standards* and AASB 2010–2: *Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements* and other applicable Australian Accounting Standards – Reduced Disclosure Requirements.

The financial statements are general purpose financial statements and have been prepared in accordance with Australian Accounting Standards – Reduced Disclosure Requirements of the Australian Accounting Standards Board (AASB) and the *Associations Incorporation Act 2015 (WA)*. The association is a not-for-profit entity for financial reporting purposes under Australian Accounting Standards.

Australian Accounting Standards set out accounting policies that the AASB has concluded would result in financial statements containing relevant and reliable information about transactions, events and conditions. Material accounting policies adopted in the preparation of the 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.

Accounting Policies

a. **Income Tax**

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

b. **Plant and Equipment**

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

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 its estimated recoverable amount, the carrying amount is written down immediately to its estimated recoverable amount and impairment losses 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).

The cost of fixed assets constructed within the association includes the cost of materials, direct labour, borrowing costs and an appropriate proportion of fixed and variable overheads.

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 association 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.

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONT'D)

b. **Plant and Equipment (cont'd)**

Depreciation

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

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

Class of Fixed Asset	Depreciation Rate
Office equipment	25-67%
Office furniture	8-20%

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 and losses are recognised in profit or loss in the period in which they occur. When re-valued assets are sold, amounts included in the revaluation relating to that asset are transferred to retained surplus.

c. **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 association, are classified as finance leases.

Finance leases are capitalised by recognising an asset and a liability at the lower of the amount equal to the fair value of the leased property or the present value of the minimum lease payments, including any guaranteed residual values. Lease payments are allocated between the reduction of the lease liability and the lease interest expense for the period.

Leased assets are depreciated on a straight-line basis over their estimated useful lives where it is likely that the association will obtain ownership of the asset or ownership over the term of the lease.

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

d. **Financial instruments**

Initial recognition and measurement

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

Financial instruments are initially measured at fair value plus transaction costs, except where the instrument is classified "at fair value through profit or loss" in which case transaction costs are recognised immediately as expenses in profit or loss.

Classification and subsequent measurement

Financial instruments are subsequently measured at fair value, amortised cost using the effective interest method, or cost.

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.*

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2016

d. **Financial instruments (cont'd)**

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

They are subsequently measured at fair value with any re-measurements 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 classified as 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.

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONT'D)

d. **Financial instruments (cont'd)**

(v) *Financial liabilities*

Non-derivative financial liabilities 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 association assesses whether there is objective evidence that a financial asset has been impaired. A financial asset (or a group of financial assets) is deemed to be impaired if, and only if, there is objective evidence of impairment as a result of one or more events (a "loss event") having occurred, 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 to constitute 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 into 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 bankruptcy or other financial reorganisation; and changes in arrears or economic conditions that correlate with defaults.

When the terms of financial assets that would otherwise have been past due or impaired have been renegotiated, the association 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 when the contractual right to receipt of cash flows expires or the asset is transferred to another party whereby the entity no longer has any significant continuing involvement in the risks and benefits associated with the asset. Financial liabilities are derecognised when the related obligations are discharged or 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.

e. **Impairment of Assets**

At the end of each reporting period, the association assesses whether there is any indication that an asset may be impaired. 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, unless the asset is carried at a revalued amount in accordance with another Standard (eg in accordance with the revaluation model in AASB 116). Any impairment loss of a revalued asset is treated as a revaluation decrease in accordance with that other Standard.

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

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2016

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONT'D)

e. **Impairment of Assets (cont'd)**

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 entity 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 an impairment loss on a revalued asset is identified, this is recognised against the revaluation surplus in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation surplus for that class of asset.

f. **Employee Benefits**

Short-term employee benefits

Provision is made for the association'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.

The association's obligation for short-term employee benefits are recognised as a part of current trade and other payable in the statement of financial position.

Other long-term employee benefits

Provision is made for employees' annual leave entitlements not expected to be paid within 12 months after the end of the annual reporting period in which the employee renders the related service. Other long-term employee benefits are measured as 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 periods on government bonds that have maturity dates that approximate the terms of the obligations. Any re-measurement of obligations for other long-term employee benefits for changes in assumptions are recognised in profit or loss in the periods in which the changes occur.

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

g. **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.

h. **Trade and Other Receivables**

Trade and other receivables include amounts due from members as well as amounts receivable from customers for goods sold or services provided 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.

Accounts receivable 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(e) for further discussion on the determination of impairment losses.

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2016

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONT'D)

i. **Revenue and Other Income**

Non-reciprocal grant revenue is recognised in profit or loss when the association obtains control of the grant, it is probable that the economic benefits gained from the grant will flow to the association 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.

When grant revenue is received whereby the association incurs an obligation to deliver economic value directly back to the contributor, this is considered a reciprocal transaction and the grant revenue is recognised in the statement of financial position as a liability until the service has been delivered to the contributor, otherwise the grant is recognised as income on receipt.

The association receives non-reciprocal contributions of assets from the government and other parties for zero or a nominal value. These assets are recognised at fair value on the date of acquisition in the statement of financial position, with a corresponding amount of income recognised in profit or loss.

Donations and bequests are recognised as revenue when received.

Interest revenue is recognised using the effective interest method, which for floating rate financial assets is the rate inherent in the instrument. Dividend revenue is recognised when the right to receive a dividend has been established.

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

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

j. **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 of 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.

k. **Comparative Figures**

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

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2016

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONT'D)

l. **Trade and Other Payables**

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

m. **Provisions**

Provisions are recognised when the association has a legal or constructive obligation, as a result of past events, for which it is probable that an outflow of economic benefits will result and that outflow can be reliably measured. Provisions recognised represent the best estimate of the amounts required to settle the obligation at the end of the reporting period.

n. **Key Estimates**

(i) *Impairment – general*

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

SERVICES FOR AUSTRALIAN RURAL & REMOTE ALLIED HEALTH INCORPORATED

ABN 92 088 913 517

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2016

NOTE 2: REVENUE	2016 $	2015 $
Revenue		
Department of Health grants	9,722,180	11,401,264
Interest income	147,406	235,010
Membership fees	130,635	41,584
Conference income	-	67,617
Other income	232,384	205,939
NRRSS income	-	150,000
Mid North Coast Health income	-	34,173
Total revenue	10,232,605	12,135,587

NOTE 3: SURPLUS FOR THE YEAR	2016 $	2015 $
a. **Expenses**		
Rental expense on operating leases:	(123,187)	(102,032)
b. **Significant Revenue and Expenses**		
The following significant revenue and expense items are relevant in explaining the financial performance:		
Department of Health grants	9,722,180	11,401,264
Employee benefits expense	(844,196)	(1,168,090)
Scholarship payments	(9,549,509)	(11,051,878)
Conference expenses	-	(28,462)
Other operating expenses	(466,988)	(475,293)

NOTE 4: AUDITORS' REMUNERATION	2016 $	2015 $
Remuneration of the auditor of the association for:		
- Auditing the financial report	9,050	8,400
- Other services	6,813	8,750
Total remuneration	15,863	17,150

SERVICES FOR AUSTRALIAN RURAL & REMOTE ALLIED HEALTH INCORPORATED

ABN 92 088 913 517

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2016

NOTE 5: CASH AND CASH EQU-IVALENTS	Note	2016 $	2015 $
Cash at bank and on hand		14,872,357	15,669,665
	17	14,872,357	15,669,665

The effective interest rate on short-term bank deposits was 2.47% (2015: 2.74%)

Reconciliation of cash

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

Cash and cash equivalents		14,872,357	15,669,667

Approximately 97% of the cash funds held as at 30 June 2016, relates to scholarships that have been granted and for which future payments are required.

NOTE 6: TRADE AND OTHER RECEIVABLES	Note	2016 $	2015 $
CURRENT			
Trade and other receivables		1,320	6,800
GST receivable		11,311	89,772
Total current trade and other receivables	17	12,631	96,572

NOTE 7: OTHER CURRENT ASSETS	2016 $	2015 $
CURRENT		
Prepayments	10,243	21,508

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2016

NOTE 8: PLANT AND EQUIPMENT	2016 $	2015 $
Office equipment:		
At cost	156,978	156,978
Accumulated depreciation	(130,627)	(119,745)
	26,351	37,233
Office furniture:		
At cost	98,755	98,755
Accumulated depreciation	(55,641)	(44,986)
	43,114	53,769
Total plant and equipment	69,465	91,002

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 $	Office Furniture $	Total $
Balance at 1 July 2015	37,233	53,769	91,002
Depreciation expense	(10,882)	(10,655)	(21,537)
Carrying amount at 30 June 2016	26,351	43,114	69,465

SERVICES FOR AUSTRALIAN RURAL & REMOTE ALLIED HEALTH INCORPORATED

ABN 92 088 913 517

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2016

NOTE 9: ACCOUNTS PAYABLE AND OTHER PAYABLES		2016 $	2015 $
CURRENT			
Trade payables		1,657	23,166
Wages and superannuation accrual		8,660	56,971
Provision for annual leave		34,732	58,497
Income in advance		-	3,988
Other payables		28,826	53,877
Total trade and other payables		73,875	196,499
a. Financial liabilities at amortised cost classified as accounts payable and other payables			
Accounts payable and other payables		73,875	196,499
Less wages and superannuation accrual		(8,660)	(56,971)
Less provision for annual leave		(34,732)	(58,497)
Less income received in advance		-	(3,988)
Less other payables		(28,826)	(53,877)
Financial liabilities as trade and other payables	17	1,657	23,166

NOTE 10: PROVISIONS	2016 $	2015 $
CURRENT		
Current long service leave provision	40,203	49,996
NON-CURRENT		
Non-current long service leave provision	10,279	11,890
Total provisions	50,482	61,886
Analysis of long service leave provision		
Opening balance at 1 July 2015		61,886
Additional provisions		7,267
Amounts used		(18,671)
Total provisions		50,482

NOTE 11: LEASE LIABILITY	2016 $	2015 $
Current	4,277	4,277
Non-current	5,702	9,979
Total lease liability	9,979	14,256

NOTE 12: CAPITAL AND LEASING COMMITMENTS	2016 $	2015 $
a. **Finance Lease Commitment**		
Payable – minimum lease payments:		
– not later than 12 months	4,704	4,704
– between 12 months and five years	6,273	10,977
Minimum lease payments	10,977	15,681

The finance lease for the photocopier, which commenced in the 2015 financial year, is a 60-month lease, expiring in October 2018. Lease payments are payable monthly in advance.

b. **Operating Lease Commitments**		
Non-cancellable operating leases contracted for but not capitalised in the financial statements		
Payable – minimum lease payments:		
– not later than 12 months	29,640	115,454
– between 12 months and five years	-	29,144
Total operating lease commitments	29,640	144,598

The property lease commitment is a non-cancellable operating lease with a three-year term that expires 30 September 2016, with rent payable monthly in advance.

Contingent rental provisions within the lease agreement require that the minimum lease payments shall be increased by the lower of the change in the consumer price index or 4% per annum.

SARRAH have entered into a new month to month leasing arrangement commencing on 1 September 2016.

NOTE 13: CONTINGENT LIABILITIES AND CONTINGENT ASSETS

The committee is not aware of any contingent liabilities or contingent assets.

SERVICES FOR AUSTRALIAN RURAL & REMOTE ALLIED HEALTH INCORPORATED

ABN 92 088 913 517

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2016

NOTE 14: EVENTS AFTER THE REPORTING PERIOD

The ongoing viability of the organisation, under current operations, is dependent on government decisions in relation to grant programs, in particular future funding for scholarships. It is not anticipated that these decisions will be made until the second half of the 2017 financial year end.

NOTE 15: RELATED PARTY TRANSACTIONS

Related party transactions

There were no related party transactions for the period 1 July 2015 to 30 June 2016.

NOTE 16: CASH FLOW INFORMATION

	2016 $	2015 $
Reconciliation of cash flow from operations with profit		
(Deficit)	(775,746)	(740,917)
Cash flows excluded from profit attributable to operating activities		
Non-cash flows in profit:		
- depreciation expense	21,537	23,365
Changes in assets and liabilities		
- decrease / (increase) in trade and other receivables	83,941	(69,886)
- decrease in other assets	11,245	30,698
- (decrease) / increase in trade and other payables	(122,624)	22,896
- (decrease) in other liabilities	-	(48,422)
- (decrease) in provisions	(11,404)	(5,326)
Total	(793,031)	(787,592)

NOTE 17: KEY MANAGEMENT PERSONNEL COMPENSATION

The totals of remuneration paid to key management personnel (KMP) of the association during the year are as follows:

	2016 $	2015 $
Key management personnel compensation		
- Short-term benefits	216,463	182,956
- Post-employment benefits	20,564	13,479
	237,027	196,435

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2016

NOTE 18: FINANCIAL RISK MANAGEMENT

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

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	2016 $	2015 $
Financial assets			
Cash and cash equivalents	5	14,872,357	15,669,665
Trade and other receivables	6	12,631	96,572
Total financial assets		14,884,988	15,766,237
Financial liabilities			
Financial liabilities at amortised cost:			
– Trade and other payables	9	1,657	23,166
– Lease liability	11	9,979	14,256
Total financial liabilities		11,636	37,422

NOTE 19: ASSOCIATION DETAILS

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

Services for Australian Rural and Remote Allied Health Incorporated
Ground Floor, 40 Thesiger Court
Deakin, ACT 2600

SERVICES FOR AUSTRALIAN RURAL & REMOTE ALLIED HEALTH INCORPORATED

ABN 92 088 913 517

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2016

STATEMENT BY MEMBERS OF THE COMMITTEE

In the opinion of the committee, the financial report as set out on pages 1 to 18:

1. Give a true and fair view of the financial position of Services for Australian Rural and Remote Allied Health Incorporated during and at the end of the financial year of the association ending on 30 June 2016.
2. At the date of this statement, there are reasonable grounds go believe that Services for Australian Rural and Remote Allied Health Incorporated will be able to pay its debts as and when they fall due.

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

President

Tanya Lehman

Treasurer

Helen McGregor

Dated this 13th day of September 2016

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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF SERVICES FOR AUSTRALIAN RURAL AND REMOTE ALLIED HEALTH INCORPORATED

Report on the Financial Report

We have audited the accompanying financial report of Services for Australian Rural and Remote Allied Health Incorporated (the association), which comprises the statement of financial position as at 30 June 2016, 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 certification by members of the Board on the annual statements giving a true and fair view of the financial position of the association.

Board Members Responsibility for the Financial Report

The Board Members of the association are responsible for the preparation of the financial report that gives a true and fair view in accordance with Australian Accounting Standards – Reduced Disclosure Requirements and the *Associations Incorporation Act 2015 (WA)* 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 whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the association'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 entity'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.

bellchambers barrett

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF SERVICES FOR AUSTRALIAN RURAL AND REMOTE ALLIED HEALTH INCORPORATED

Opinion

In our opinion the financial report of Services for Australian Rural and Remote Allied Health Incorporated is in accordance with the *Associations Incorporation Act 2015 (WA)*, including:

(i) giving a true and fair view of the association's financial position as 30 June 2016 and of its performance for the year ended on that date and the other matters required by the *Associations Incorporation Act 2015 (WA)*;

(ii) we have obtained all the information and explanations required;

(iii) complying with Australian Accounting Standards – Reduced Disclosure Requirements and the *Associations Incorporation Act 2015 (WA)*; and

(iv) proper accounting records and other records have been kept by Services for Australian Rural and Remote Allied Health Incorporated as required by the *Associations Incorporations Act 2015 (WA)*.

Emphasis of Matter

Without modifying our opinion, we draw attention to Note 14 in the financial report. The ongoing viability of the organisation, under current operations, is dependent on government decisions in relation to grant programs, in particular future funding for scholarships. It is not anticipated that these decisions will be made until the second half of the 2017 financial year end.

Shane Bellchambers, FCA
Registered Company Auditor
BellchambersBarrett

Canberra, ACT
Dated this 14th day of September 2016

06 APPENDICIES

SARRAH meets with individuals and organisations from across government and rural and remote allied health sector to disucss and address the need for access to equitable, sustainable and consistent allied health services. Through broad consultation, SARRAH aims to provide positions and proposals that are relevant and address the needs of people living in the bush.

APPENDIX A: SARRAH SUBMISSIONS

During the reporting period SARRAH provided submissions and discussion papers to the Department of Health, Senate Committees and other organisations. In 2014–15 SARRAH developed the following submissions:

- **Submission to the Primary Health Care Advisory Group Survey:** 03/09/2015
- **Submission to the House of Representatives Standing Committee on Health Inquiry into Chronic Disease Prevention and Management in Primary Health Care:** 24/09/2015
- **Submission to the review of the National Safety and Quality Health Service Standards:** 27/10/2016
- **Submission to the MBS Review Taskforce:** 9/11/2015
- **Submission to the DVA Review of Allied Health & Dental Arrangements:** 21/12/2015
- **Submission to the Treasurer – Federal Budget Submission 2015–16:** 19/02/2016
- **Submission to the Senate Community Affairs Reference Committee Inquiry into the Future of Australia's Aged Care Sector Workforce:** 10/03/2016
- **Submission to the NDIA on its Information, Linkages and Capacity Building Commissioning Framework:** 27/04/2016
- **Submission to the Department of Health: National Strategic Framework for Chronic Conditions:** 22/06/2016.

APPENDIX B: MEETINGS AND FORUMS

During the reporting period SARRAH attended the following meetings and forums. SARRAH met with Australian Government departments and authorities, parliamentarians, Primary Health Networks, service providers, universities and a range of other organisations:

Australian Government departments and authorities

- **Department of Health (DoH):** 12/4/2016, 27/4/2016, 3/5/2016 and 31/5/2016
- **DoH: Dental Relocation & Infrastructure Scheme Steering Committee:** 19/8/2015, 5/11/2015, 9/12/2015, 7/4/2016 and 26/5/2016
- **DoH: Health Peak and Advisory Bodies Programme Information Session:** 28/7/2015
- **DoH: Health Workforce Scholarship Programme Consultation:** 1/9/2015
- **DoH: Information Session on Modified Monash System:** 2/12/2015
- **DoH: Medicare Benefits Schedule Review Stakeholder Forum:** 8/7/2015 and 5/4/2016
- **DoH: Podiatry and Aboriginal Workforce:** 7/3/2016
- **DoH: Private Health Insurance Consultation:** 17/11/2015
- **Department of Human Services: Medicare Stakeholder Consultative Group:** 28/7/2015, 8/3/2016 and 11/5/2016
- **Department of Veterans Affairs (DVA): Health Committee:** 24/9/2015
- **DVA: Consultative Forum:** 23/3/2016
- **National Disability Insurance Agency (NDIA):** 27/11/2015 and 1/3/2016
- **NDIA: Assistive Technology Forum:** 29/4/2016
- **NDIA: Remote Disability Services Provider Forum:** 22/3/2016
- **NDIA: Rural and Remote Allied Health Workforce Development:** 26/5/2016.

Internal SARRAH meetings

- **Achievements Working Group:** 26/2/2016
- **Advisory Committee Meeting:** 30/7/2015, 24/9/2015, 26/11/2015, 21/1/2016, 17/3/2016 and 19/5/2016
- **Audit Committee: 3**0/7/2015, 21/9/2015, 30/10/2015, 20/11/2015, 22/1/2016, 19/2/2016, 18/3/2016, 15/4/2016 and 17/6/2016
- **Board:** 25/8/2015, 27/10/2015, 30/11/2015, 27/1/2016, 23/2/2016, 10/5/2016 and 28/6/2016
- **Conference Organising Committee (Including abstract review, conference program, sponsorship and social committee meetings):** 19/8/2015, 16/9/2015, 9/12/2015, 19/1/2016, 29/1/2016, 8/2/2016, 16/2/2016, 26/2/2016, 2/3/2016, 16/3/2016, 29/3/2016, 30/3/2016, 15/4/2016, 19/4/2016, 4/5/2016, 25/5/2016, 14/6/2016 and 29/6/2016
- **Managers' Meetings:** 18/8/2015, 1/8/2015, 15/9/2015, 29/9/2015, 27/10/2015, 24/11/2015, 21/1/2016, 3/2/2016, 17/2/2016, 16/3/2016, 22/3/2016, 5/4/2016, 3/5/2016, 17/5/2016 and 31/5/2016
- **NAHSSS Reference Group:** 27/11/2015 and 5/2/2016
- **Northern Territory members:** 21/8/2015, 22/10/2015, 11/12/2015, 12/2/2016 and 9/6/2016.

Internal SARRAH meetings (Continued)

- **Novartis project (Including launch of final report):** 11/9/2015, 18/9/2015 and 2/12/2016
- **Secretariat staff:** 8/7/2015, 12/8/2015, 9/9/2015, 21/10/2015, 12/11/2015, 9/12/2015, 13/1/2016, 5/2/2016, 10/2/2016, 9/3/2016, 14/4/2016, 11/5/2016 and 8/6/2016
- **Social media training:** 25/9/2015
- **Staff Career Transition Workshop:** 11/3/2016
- **Working Group on ILC Commissioning Framework:** 31/3/2016
- **2015 Summit Planning Group Meeting:** 29/7/2015 and 10/9/2015
- **2015 Summit:** 11-14/10/2015.

Parliamentarians and Committees

- **House of Representative Standing Committee on Health Inquiry into Chronic Disease Prevention and Management in Primary Health Care:** 21/8/2015
- **National Federal Party Room Event:** 9/2/2015
- **Parliamentary Friendship Group for Rural and Remote Allied Health:** 24/2/2016
- **Parliamentary Rural and Regional Roundtable Meeting:** 13/11/2015 and 6/4/2016
- **Rohan Ramsey MP:** 23/11/2015
- **Senator Wang:** 19/10/2015 and 9/11/2015
- **Speech by The Hon. Susan Ley:** 28/10/2015
- **Speech by Senator Richard Di Natale:** 30/9/2015.

Primary Health Networks

- **Darling Downs West Moreton Primary Health Network:** 27/5/2016
- **Hunter New England Central Coast Primary Health Network:** 18/4/2016
- **Murray Primary Health Network:** 15/3/2016
- **Murrumbidgee Primary Health Network:** 6/4/2016
- **Northern Queensland Primary Health Network:** 12/5/2016
- **Western New South Wales Primary Health Network:** 4/4/2016
- **Western Queensland Primary Health Network:** 1/6/2016.

Service providers

- **Aspen Medical:** 10/12/2015
- **Marathon Health:** 10/2/2016, 18/3/2016 and 6/4/2016.

State and Territory

- **New South Wales Ministry of Health:** 18/3/2016
- **New South Wales Ministry of Health: Presentation of report *Addressing Diabetes-Related Foot Disease in Indigenous NSW*:** 23/5/2016
- **Queensland Chief Allied Health Officer:** 12/2/2015.

Universities

- **Australian Catholic University:** 23/11/2015 and 26/4/2016
- **Central Queensland University:** 19/2/2016
- **Charles Sturt University:** 17/11/2015 and 2/3/2016
- **Curtin University:** 13/4/2016
- **Deakin University:** 26/11/2015
- **Edith Cowan University:** 12/11/2015 and 6/5/2016
- **Griffith University:** 22/2/2016
- **La Trobe University:** 16/2/2016
- **Macquarie University:** 16/2/2016
- **Murdoch University:** 8/4/2016
- **Queensland University of Technology:** 10/5/2016
- **Royal Melbourne Institute of Technology:** 14/12/2015
- **Southern Cross University:** 22/3/2016
- **Sunshine Coast University:** 10/12/2015
- **Sydney University:** 11/2/2016
- **University of Canberra:** 18/12/2015 and 23/2/2016
- **University of Melbourne:** 4/1/2016
- **University of Newcastle:** 17/2/2016 and 3/5/2016
- **University of New England:** 9/5/2016
- **University of Notre Dame:** 5/4/2016
- **University of Queensland:** 14/4/2016
- **University of Queensland: Presentation to Speech Pathology Students:** 10/9/2015
- **University of South Australia:** 17/12/2015
- **University of Southern Queensland:** 15/2/2016
- **University of Wollongong:** 15/12/2015
- **Victoria University:** 8/2/2016.

Other meetings and forums

- **Aboriginal and Torres Strait Islander Palliative Care:** 1/3/2016
- **ACT Chief Allied Health Officer:** 25/11/2015
- **Allied Health Innovative Workshops follow-up:** 9/9/2015
- **Australian Allied Health Forum:** 18/8/2015, 16/2/2016, 14/6/2016 and 21/6/2016
- **Australian Dental Association:** 4/3/2016
- **Australian Rural Leadership Foundation:** 11/2/2016
- **Australasian Society of Association Executives Conference:** 24–25/5/2016
- **Brien Holden Vision:** 7/9/2015
- **Carers Australia Media Launch and Parliamentary Friends of Carers Group:** 19/8/2015
- **Canberra Business Chamber Gala Dinner:** 18/11/2015
- **Centre for Remote Health:** 16/2/2016
- **Climate and Health Alliance Members Meeting:** 1/7/2015
- **Health For Life Workshop: 4/11/2015**
- **Health Workforce Scholarship Programme Consultation Meeting:** 1/9/2015
- **Health Workforce Queensland Rural Health Professional Programme Presentation:** 25/6/2016
- **HESTA Functions:** 5/11/2015 and 2/6/2016
- **Homelessness Prevention Week 2015:** 3/8/2015
- **ICC Sydney Breakfast:** 8/9/2015
- **Independent Hospital Pricing Authority Small Rural Hospital Working Group:** 16/9/2015
- **Indigenous Allied Health Australia:** 2/3/2016
- **Indigenous Allied Health Forum:** 6/8/2015
- **Mid North Coast Health Training:** 9/2/2016
- **National Aboriginal and Torres Strait Islander Health Workers Association:** 2/11/2015
- **National Allied Health Conference Organising Committee:** 9/11/2015, 11/11/2015, 7/4/2016, 21/4/2016 and 19/5/2016
- **NSW Careers Advisors Association Conference:** 21/9/2015
- **NT Advisory Forum – Medical Outreach Indigenous Chronic Disease Program:** 22/7/2015
- **National Primary Health Care Partnership:** 23/9/2015 and 3/3/2016
- **National Rural Health Alliance:** 28/4/2016 and 16/6/2016
- **National Rural Health Alliance and Australian College of Nursing:** 10/11/2015
- **National Rural Health Alliance Council:** 24/8/2015, 11 – 12/9/2015, 7/12/2015, 18/4/2016 and 20/6/2016
- **Official Launch of a World of Rural Health:** 16/3/2016
- **Palliative Care Event-Improving Access to Palliative Care:** 24/11/2015
- **Pharmacy Guild of Australia Annual Dinner:** 24/11/2015.

Other meetings and forums (Continued)

- **Philanthropy Australia:** 15/3/2016
- **Philanthropy Australia: ACT – Associate Membership Meeting:** 16/7/2015
- **Philanthropy Meets Parliament Summit:** 9/9/2015
- **Primary Health Care Advisory Group briefing:** 21/8/2015
- **Public Health Association of Australia:** 9/11/2015
- **Rural Health Professionals Programme Evaluation Reference Committee:** 23/3/2016, 25/5/2016 and 31/5/2016
- **Rural Health Workforce Australia:** 5/11/2015 and 4/5/2016
- **Social Determinants of Health Alliance:** 16/3/2016
- **Social Media Consultant:** 11/2/2016
- ***The Leading Edge* by Dr Stephen Langford (Royal Flying Doctor Service Book Presentation):** 4/4/2016
- **WA Occupational Therapy Association:** 25/5/2016
- **Westpac NFP Financial Forum:** 24/2/2016.

APPENDIX C: MEDIA RELEASES, MEDIA COVERAGE AND ARTICLES

Media Releases

- **Higher demand expected for Allied Health Scholarships:** 11/08/2015
- **Rural Health Award targets spinal health in rural communities – Kate Scanlon Award:** 12/10/2015
- **SARRAH Summit 2015:** 14/10/2015
- **Senator Wang – Question Without Notice – Allied Health Scholarships:** 15/10/2015
- **Hidden Harms: How concealed Budget cuts are killing Australia's health sector:** 10/11/2015
- **Allied Health saving the health system more than $175m each year:** 02/12/2015
- **Election 2016: Where do our politicians stand on rural health?:** 23/05/2016
- **Election 2016: SARRAH releases Rural and Remote Allied Health Report Card ahead of election:** 28/06/2016.

Media Coverage

- **Joint National Press Club of Australia Address with the Public Health Association of Australia and the Palmerston Association – Hidden Harms: How Concealed Budget Cuts Are Killing Australia's Health Sector:** 10/11/2015.

SARRAH CEO COMPLETED EIGHT RADIO INTERVIEWS AND ONE NEWSPAPER INTERVIEW AS A RESULT OF THE MEDIA RELEASES:

- **ABC Goulburn Murray – NSW/VIC:** 14/10/2015
- **ABC Darwin – NT:** 14/10/2015
- **ABC Riverina – NSW:** 14/10/2015
- **Gold Coast's Good Taste Radio Station Juice 107.3 – QLD:** 14/10/2015
- **Hot FM – QLD:** 14/10/2015
- ***Macleay Argus* – NSW:** 14/10/2015
- **FM Gippsland – NSW:** 28/06/2016
- **3BO Star FM Bendigo – NSW:** 28/06/2016
- **ABC Western – NSW:** 28/06/2016.

Articles

- **Geraldton Newspapers – WA:** 14/10/2015
- ***Macleay Argus* – NSW:** 14/10/2015
- **Central Australia Aboriginal Media Association – NT:** 14/10/2015
- ***Partyline* (National Rural Health Alliance):** 18/04/2016.

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