S·A·R·R·A·H

Services for Australian
Rural and Remote Allied Health

ANNUAL REPORT

2014 - 2015

What is the design about?

Background Story

The approach for the design of 2014-15 SARRAH annual report was to deliver a message of progression, coming into the organisations 20th year, it's important to show that SARRAH not only play an important role in the allied health sector, but we are also a progressive and innovative organisation.

The photograph on the cover is by Australian photographer Dan Proud, and perfectly captures the essence of rural and remote Australia. The design throughout this report is representative of an innovative and modern approach to allied health. The colours are representative of remote Australia. The triangles have a modern look and feel to them, and they represent the mountains of rural Australia. The lines between the triangles connect the elements of the piece together and illustrates how allied health professions work in tandem to achieve better health outcomes in rural and remote communities.

2014-2015 SARRAH Annual Report

Office Address:
40 Thesiger Ct
Deakin, ACT 2600

Mailing Address:
Services for Australian Rural and Remote Allied Health
PO Box 74, Deakin West ACT 2600

ABN:	92 088 913 517
Phone:	+61 2 6285 4960
Toll-free:	1800 338 061
Fax:	+61 2 6162 4094
Email:	sarrah@sarrah.org.au

You can find out more about SARRAH at our website: **www.sarrah.org.au**

Services for Australian Rural and Remote Allied Health exists so that rural and remote Australian Communities have allied health services that support equitable and sustainable health and wellbeing.

SARRAH receives core funding from the
Australian Government Department of Health

Table of Contents

Introduction

Welcome to SARRAH

Welcome to the 2014-15 annual report for Services for Australian Rural and Remote Allied Health (SARRAH).

This year SARRAH is celebrating its 20th anniversary as a grassroots organisation supporting rural and remote Australian communities. Enabling them to have access to allied health services, 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) working in the public and private sector. 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 these communities.

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 support 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 recognise 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.

MISSION

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

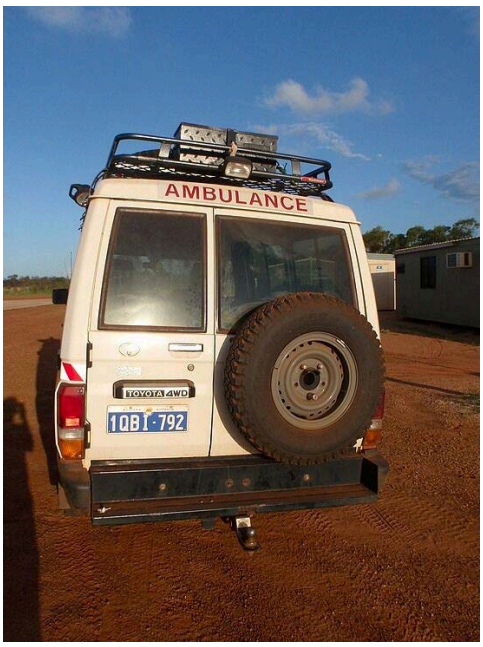
VISION

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; and
- 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 grass roots AHP;
- Consultation;
- Achievement orientation;
- Connectedness to community; and
- Can-do attitude.

President's Report

I am proud to present the SARRAH annual report for 2014-15, a year of change and celebration as we enter our 21st year of operation.

SARRAH has a proud 20 year history of working to improve the capacity, quality and safety of Australia's health care system for rural and remote Australians. SARRAH was formed by AHPs living and working in rural and remote Australia to provide a national voice and focus on the health issues faced by communities where they practice. SARRAH has evolved into a mature peak body with strong connections across the health sector while maintaining a firm connection with the individuals and communities it represents.

This year we:

- Convened the 11th biennial SARRAH national conference in Kingscliff, New South Wales during September 2014 where speakers from all around the country contributed to building stronger and more collaborative links between AHPs;
- Continued to expand our political influence through engaging with the Parliamentary Friendship Group for Rural and Remote Allied Health on several occasions;
- Prepared high quality submissions to various Senate enquiries and departmental reviews as well as developed a position paper on Models of Care;
- Provided ongoing support to 1288 new and existing AHP and student scholarship recipients enhancing their ability to develop, learn and succeed in rural and remote communities. By administering the Nursing and Allied Health Scholarship and Support Scheme on behalf of the Australian Government Department of Health, SARRAH has contributed again to building a better trained and more resilient rural and remote AHP workforce;
- Contributed to a 70.88% increase in the number of AHPs delivering individually funded rural, remote and very remote early intervention services, on behalf of the Australian Government Department of Social Services (DSS) since the establishment of the National Rural and Remote Support Service in 2013;
- Supported two research projects under the Australian National University Internship Program. Individual reports were produced by the interns, titled:
  - Investigating the efficacy of Allied Health: reducing costs and improving outcomes in the treatment of diabetes, osteoarthritis and stroke by Virginia DeCourcy. Novartis is currently conducting economic modelling on the outcomes of this research and will produce a report during October 2015; and

- Mapping rural and remote early childhood intervention therapy services by Maximiliane Hanft.

- Strengthened our social media and online presence with an increase in Facebook likes to 1294 and a Twitter audience of 527. We also upgraded the SARRAH Website.

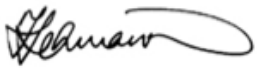
At the 2014 Annual General Meeting held during the SARRAH Conference, we farewelled outgoing members and welcomed new members to the Board. We bid farewell to Kate Osborne, Sheila Keane and Kathryn Fitzgerald, and welcomed Kato Matthews, Susan Nancarrow and Petra Bovery-Spencer to the Board. We also saw a change in the skills-based Board appointed member, with Roslyn Jackson (financial expertise) leaving in November 2014, and Kirrily Dear (fundraising, philanthropy and finance) joining us in April 2015.

This year, the SARRAH Board has continued to work with CEO Rod Wellington to strengthen the governance, strategy and policies of SARRAH. While a lot of these 'back of house' functions go largely unnoticed by the membership and SARRAH's stakeholders, they are critical to SARRAH's effectiveness, viability and sustainability as an organisation. On behalf of the Board, I acknowledge and thank CEO Rod Wellington, and the SARRAH Secretariat staff, for their tireless work.

These 'back of house' improvements have prepared SARRAH well for the challenges ahead. In the 2015 Budget, the Federal Government announced their intention to rationalise the special purpose health funds (from which SARRAH receives Secretariat funding), and consolidate health workforce scholarships under a single administrator (SARRAH is one of 6 current administrators) from July 2016. These announcements foreshadow major changes ahead for SARRAH. While we are busily preparing for the release of the tender documents, we are also progressing work on diversifying our income and preparing contingency plans for massive expansion or contraction of the organisation.

Never before has it been more critical for SARRAH members to rally together. SARRAH needs you to become more active, to entice old members back, and encourage colleagues to join. As the population ages, the burden of chronic disease and disability increases, our regional, rural, remote and very remote communities continue to miss out on essential allied health services.

We have made some incredible progress in recent years, and the content of this Annual Report demonstrates that SARRAH continues to make a significant impact and punch well above our weight. Together we can work towards ensuring that rural and remote Australian communities have allied health services that support equitable and sustainable health and well-being.



Tanya Lehmann
President

SARRAH 2014-15
Overview Infographics

Turnover
$12.1 million in 2014-15

Membership

27 allied health professions represented

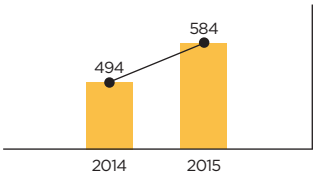
75% of membership live or operate in rural and remote regions of Australia

SARRAH has gained **5 Corporate members** in 2014-15

National Rural and Remote Support Service

70.8% increase of **registered rural and remote allied health providers** with Australian Government Department of Social Services (DSS) early intervention provider panel

increase in membership
from **494** in 2014 to **584** in 2015



Nursing and Allied Health Scholarship and Support Scheme

1,288 scholarship recipients as at June 2015

874 scholarships awarded in 2014-15

28.4% success rate for eligible applications in 2014-15

3,478 applications received in 2014-15

$11.2 million in Scholarship funding committed in 2014-15

Research and Policy Development

2 **research reports** publicly released

developed **9 submissions** responding to **health policy** matters

6 **working groups** on **organisation and sector topics**

10 **meetings** with **parliamentarians**

Media and Community Engagement

increase in Facebook '**Likes**' from **750** in June 2014 to **1294** in June 2015

increase in Facebook '**Reach**' from **900** in June 2014 to **1373** in June 2015

9 media releases
6 media articles
6 media interviews
1 press conference
11 website publications

Distribution of 31 e-newsletters including:

- **12** e-bulletins
- **13** program newsletters
- **2** special broadcasts
- **4** board meeting communiques

SARRAH Conference

4 days

184 delegates

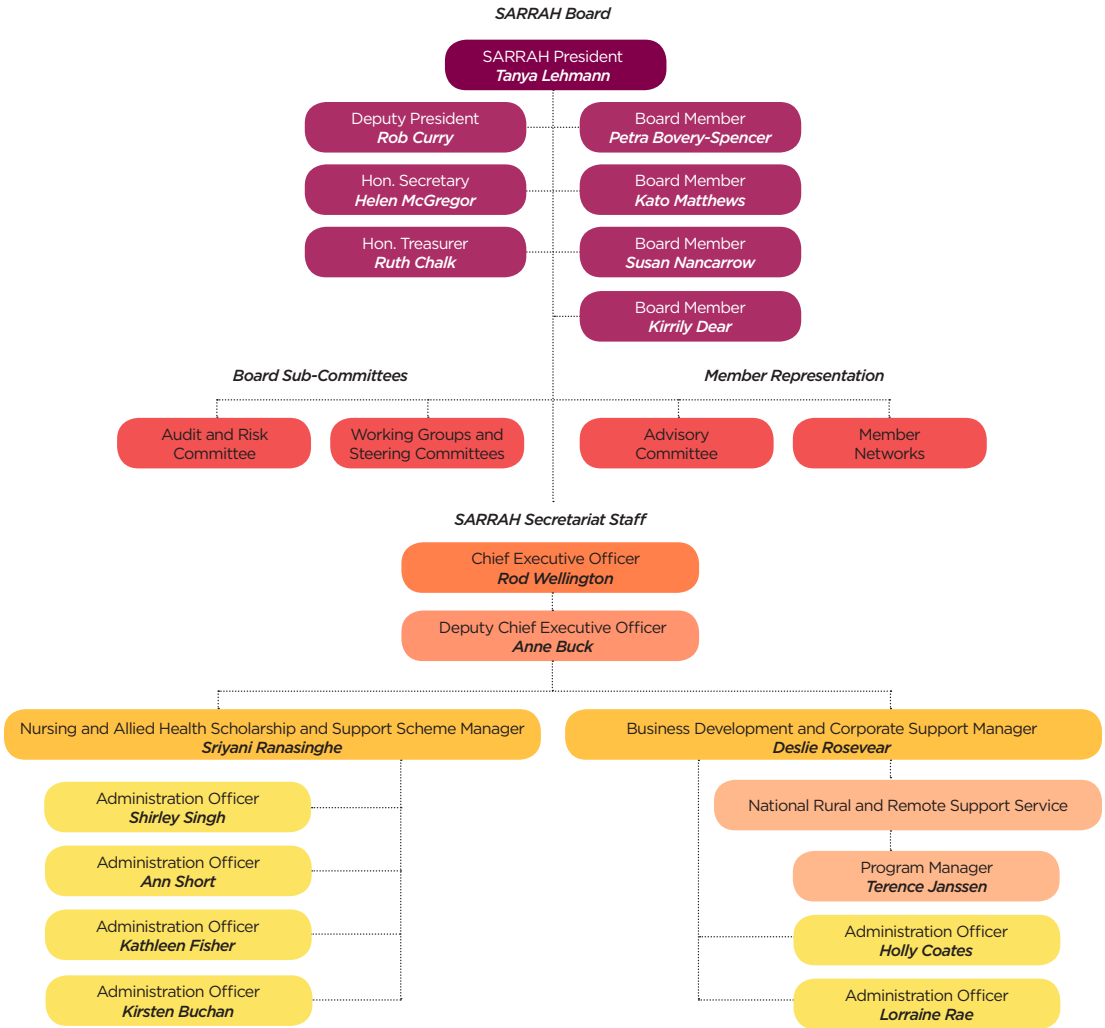
8 keynote speakers

59 presentations

Corporate Governance

Organisation Structure

SARRAH has a board supported by committees, working groups and the secretariat which completes the tasks associated with achieving the strategic direction of the organisation.



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 dictating the strategic direction of SARRAH.

The current SARRAH Board comprises 8 members, with an additional Board member position currently vacant. In 2014-15 the Board membership was as follows:

Name	Position	Appointment
Tanya Lehmann	President	Appointed at 2014 AGM
Rob Curry	Deputy President	Appointed at 2014 AGM
Helen McGregor	Honorary Secretary	Appointed at 2014 AGM
Ruth Chalk	Honorary Treasurer	Appointed at 2013 AGM
Petra Bovery-Spencer	Board member	Appointed at 2014 AGM
Susan Nancarrow	Board member	Appointed at 2014 AGM
Kato Matthews	Board member	Appointed at 2014 AGM
Roslyn Jackson	Board member	Appointed August 2013 under Section 11.3(b) of Constitution Resigned November 2014
Kirrily Dear	Board member	Appointed March 2015 under Section 11.3(b) of Constitution

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 2014-15 was as follows:

Name	Appointment Status
Ruth Chalk (Chair)	Appointed September 2013
Tanya Lehmann	Resigned December 2014
Helen McGregor	Appointed December 2014
Petra Bovery-Spencer	Appointed December 2014
Roslyn Jackson	Resigned November 2014

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 of SARRAH. 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 2014-15, the Advisory Committee met 4 times via teleconference.

Key achievements of the Advisory Committee in 2014-15 were:

- Established a Board – Advisory Committee buddy system in which Board members are linked with SARRAH Advisory Committee members;
- Reviewed Network Coordinator Guidelines to help Network Coordinators understand and fulfil their roles; and
- Developed a Buddy Support Program for SARRAH members which is an informal process providing new SARRAH members, especially those with limited rural/ remote experience, with links to Network Coordinators on the Advisory Committee.

The Network Coordinators as at 30 June 2015 are:

Position	Committee Member	Position	Committee Member
NSW Coordinator	Catherine Maloney	Exercise and Sports Science Coordinator	Gregg Orphin
NT Coordinator	Heather Jensen	Medical Imaging Coordinator	Hazel Harries-Jones
SA Coordinator	Kate Osborne	Optometry Coordinator	Luke Arkapaw
VIC Coordinator	Kate Roberts	Oral Health Coordinator	Cathryn Carboon
QLD Coordinator	Selina Taylor	Physiotherapy Coordinator	Kerstin McPherson
TAS Coordinator	David Gould	Pharmacy Coordinator	Lindy Swain
ACT Coordinator	Vacant	Podiatry Coordinator	Cassandra Bonython
WA Coordinator	Maeva Hall	Psychology Coordinator	Kerrie Kelly
Student Coordinator	Ankur Verma	Rural and Remote Allied Health Research Alliance	Vacant
Audiology / Audiometry Coordinator	Vaughan Grigor	Social Work Coordinator	Rosalie Kennedy
Dietetics Coordinator	Ilana Jorgensen	Speech Pathology Coordinator	Claire Salter

SARRAH Board (cont')

2016 Conference Organising Committee

A Conference Organising Committee comprised of SARRAH members from South Australia was formed in January 2015 to oversee the coordination of the SARRAH Rural and Remote Allied Health Conference in 2016.

The members of this committee are:

Name	Name
Kate Osborne (Chair)	Elaine Ashworth
Tanya Lehmann	Bronwyn Venning
Meredith Stewart	Fiona Murray
Kathy Relihan	Amy Trengrove
Brett Webster	Wendy Thiele
Amy Stephenson	Hayley Collyer
Verity Paterson	Julie Tunbridge

The committee has met 4 times this year and has decided on the theme for the conference. Further information on the conference can be found later in this report.

Working Groups

SARRAH establishes a range of working groups comprising Board and Advisory Committee members to assist with various projects and activities. In 2014-15 working groups met to discuss and complete work related to:

- Developing a submission for the National Disability Insurance Scheme Safety and Quality Framework; and
- Drafting a position paper on models of care.

Other working groups have been established to enhance the areas of financial diversification, fundraising, membership engagement and membership recruitment and marketing. Meetings are held on an as required basis.

SARRAH Secretariat

The Secretariat is a small team that supports both the membership and strategic direction of the organisation. In 2014-15, SARRAH identified a range of areas where there was scope to streamline processes and organise priorities, to increase its responsive capacity within a rapidly changing political and economic environment.

Changes to the organisational structure of the Secretariat included:

- Establishing a Deputy CEO position;
- Establishing a Business Development and Corporate Support team; and
- Consolidating scholarship administration.

Following the reorganisation of the Secretariat team, SARRAH will monitor the productivity improvements throughout 2015-16 and beyond.

Operational Overview/Report

Chief Executive Officer's Report

At the beginning of 2014-15 SARRAH identified two organisational priorities:

- Diversifying SARRAH's income sources; and
- Increasing SARRAH membership numbers through the new Corporate Membership category.

Progress has been made towards these goals in 2014-15, particularly in attracting corporate members. Five organisations are now corporate members of SARRAH and this will continue to be a focus in 2015-16. SARRAH's income is still heavily dependent on government grants for both project and program administration, and to provide secretariat services to SARRAH. Other sources of income that are being pursued include philanthropic support and corporate partnerships.

SARRAH had a successful year as a strong and consistent advocate for rural and remote allied health services. SARRAH used the successful 2014 National Conference to identify rural and remote allied health priorities. The recommendations of the conference were sent to Senator Fiona Nash, Assistant Minister for Health, and have been incorporated into SARRAH's policy and advocacy activities throughout the year.

Through the Australian National University Internship program, SARRAH facilitated two major research projects exploring the impact of allied health interventions on health outcomes. These reports were a springboard for SARRAH to lobby for greater investment in rural and remote allied health services. Building on this research, SARRAH has partnered with Novartis Australia to model the economic impact of allied health services in three areas.

Administering projects and programs that assist and support rural and remote allied health services remains an important part of SARRAH's operations. As the administrator of the NAHSSS Allied Health scholarships since 2010, SARRAH has awarded and managed around 4000 scholarship recipients and over $70 million in funding. SARRAH works with the Department of Health to ensure the NAHSSS meets its objectives, and the needs of the rural and remote allied health workforce.

Another project SARRAH has delivered is the National Rural and Remote Support Service that was established to enhance rural delivery of the Department of Social Services Better Start for Children with a Disability Initiative, and Helping Children with Autism Package. Since its launch an additional 584 early intervention allied health therapists have registered, giving them access to tools such as mentoring support, professional forums and webinars.

Rod Wellington
Chief Executive Officer

SARRAH Strategic Direction and Achievements

Overview

SARRAH's strategic plan covers the period 2013 to 2016. The strategic plan identifies three domains of focus: Stakeholders, Internal Business Practice and People, Learning and Development. Goals have been established within each domain to enable SARRAH to achieve its vision:

SARRAH strives to be the recognised peak body representing and influencing reform in rural and remote allied health, with a supported and dynamic member network.

Goals and Achievements

Stakeholders

GOAL ONE: MEMBERS

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

Achievements in 2014-15:

- SARRAH offered Corporate Memberships for the first time in 2014-15, and five corporate members have since joined. Through corporate memberships, SARRAH can engage with more Allied Health Professionals (AHPs) to improve allied health services in rural and remote areas;
- Actively participated in activities including:
  - Developing policy and representation (approximately 40 members regularly engaged in these activities);
  - Coordinating the Rural and Remote Allied Health Conference;
  - Promoting rural and remote allied health careers.
- SARRAH launched a new website in 2014 which provides information about rural and remote allied health services to the general population, as well as resources to support members in rural and remote practice.

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 2014-15:

- SARRAH continued to provide leadership in the area of rural and remote health by making submissions (11), developing position papers (1), and participating in workshops, committees and consultation forums;
- SARRAH also shows leadership by auspicing research projects that demonstrate the contribution of allied health services to improve health outcomes including:
  - Mapping Rural and Remote Early Childhood Intervention Therapy Services by Maximiliane Hanft, October 2014; and

SARRAH Strategic Direction and Achievements (cont')

- Investigating the Efficacy of Allied Health: Reducing Costs and Improving Outcomes in the Treatment of Diabetes, Osteoarthritis and Stroke by Virginia DeCourcy, November 2014.

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

Achievements in 2014-15:
- SARRAH represents 27 professions across all states and territories with approximately 75% living or operating in rural and remote regions of Australia.
- SARRAH members directly contribute to improving the health and wellbeing for rural and remote Australians. This is archived through participating in meetings with politicians, policy makers and other sector stakeholders, and representing SARRAH on committees and working groups

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 2014-15:
- The SARRAH Board, Advisory Committee, sub committees and working groups, received efficient secretariat support throughout 2014-15.
- SARRAH corporate governance processes were maintained at a high standard through 2014-15 oversighted by the SARRAH Audit and Risk Committee and SARRAH Board.

GOAL FIVE:
PROJECTS AND PROGRAMS
SARRAH maintains efficient administrative systems to effectively manage projects and programs.

Achievements in 2014-15:
- 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, exceeding program targets and meeting all contractual requirements.
- SARRAH completed administering the National Rural and Remote Support Service on behalf of the Commonwealth Department of Social Services, meeting program targets and all contractual requirements.

People, Learning and Development

GOAL SIX: HUMAN RESOURCES
SARRAH recruits, fosters and values highly trained staff.

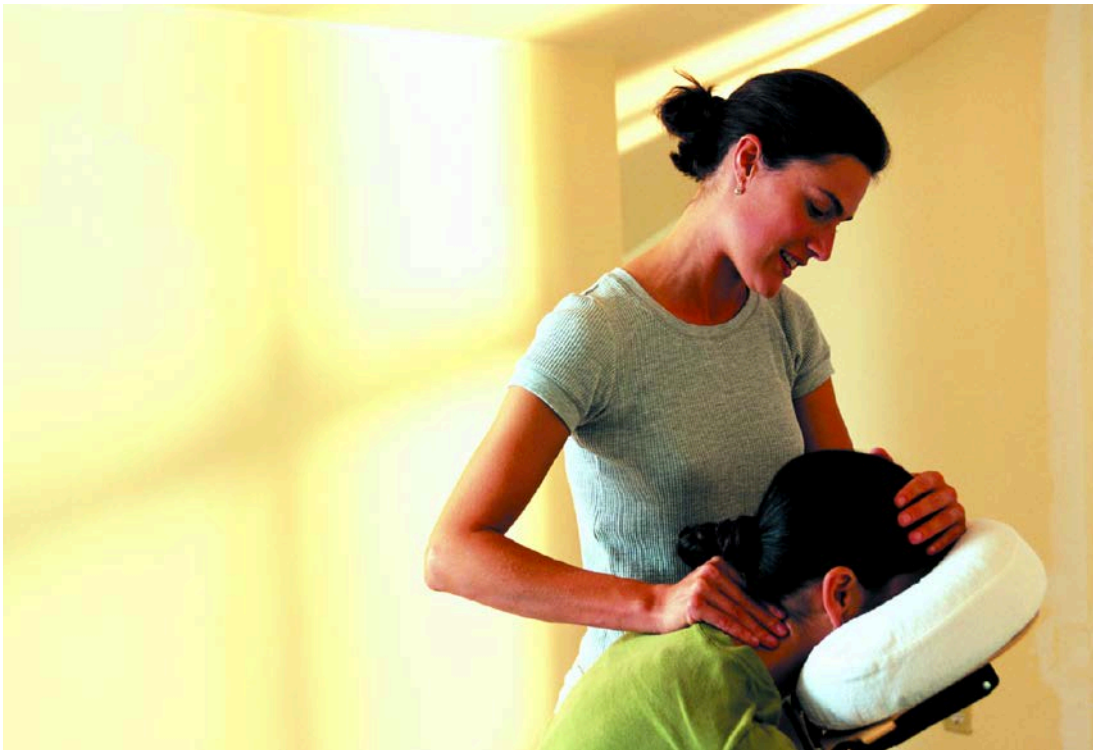
Achievements in 2014-15:

- SARRAH undertook an organisational restructure to improve staff productivity and respond to changes in the program and project administration environment. This structure provides SARRAH staff with opportunities to develop skills in new areas.

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 2014-15:

- SARRAH's information technology system experienced a major unplanned service disruption in 2014-15 due to a virus attack. The backup supports implemented were effective and the impact on SARRAH operations was minimal.



SARRAH Membership in 2014-15

SARRAH is a membership based grassroots organisation. The objective of the organisation is to reflect as broad a representation of rural and remote AHPs as possible. This is why SARRAH accepts membership from a core of 27 allied health professions and related disciplines.

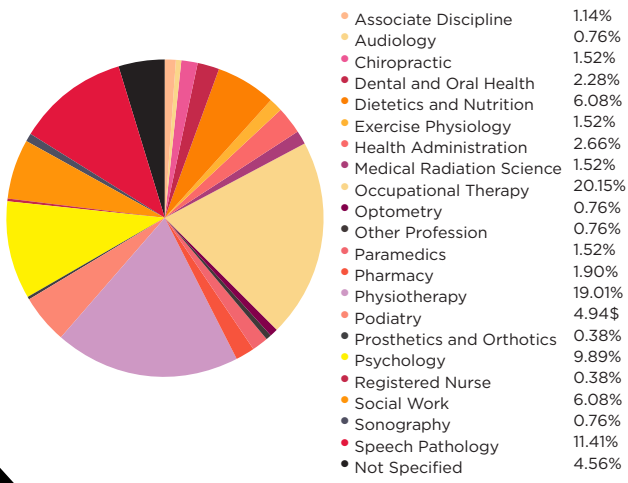
Our members are eligible to join jurisdiction and discipline based networks managed by network coordinators who sit on the Advisory Committee. SARRAH policy decisions, and broader-reaching Federal Government policy information, is distributed back to the members via their network coordinator.

Support and benefits are provided to members in the form of:

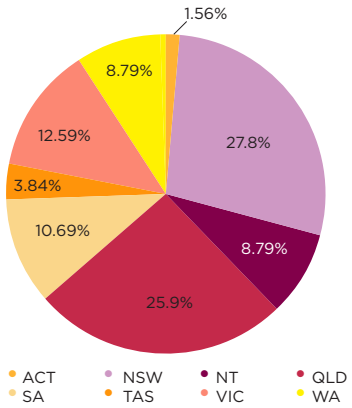
- Receiving updates and information about development and support opportunities through newsletters, social media, website updates and directly over the phone and by email;
- Contributing to the rural and remote health policy discussion by being able to provide input into position papers and submissions presented to local, state and federal parliaments;
- 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 Australian Journal of Rural Health and SARRAH publications; and
- 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 their members, and encourage new members to join. This is an area SARRAH plans to continue developing in 2015-16.

Percentage Breakdown of Membership by Discipline



Percentage Breakdown of Membership by State or Territory



2014-15 Corporate Members

In 2014 SARRAH established a new Corporate Membership category. SARRAH looks at its partnership with industry as a key enabler in achieving its aim to improve the health and wellbeing of people residing in rural and remote Australia. In recognition of this, SARRAH would like to thank the organisations who joined as corporate members in 2014-15.

aspenmedical

Federation UNIVERSITY • AUSTRALIA

marathon health

Health Network NORTHERN TERRITORY
the Northern Territory PHN

PHN country to coast
CENTRAL QUEENSLAND SUNSHINE COAST

Communication and Engagement

SARRAH has continued to raise its profile, engage with members, and sector stakeholders throughout the 2014-15 financial year through a range of communication activities as identified in its communication plan.

The communication plan informs all communication and engagement activities. It considers the issues facing rural and remote AHPs (such as workforce shortages, high workloads, travel and limited internet access), engagement has been a significant challenge historically. In 2014-15, SARRAH:

- Engaged with AHPs, politicians and local, state and federal government representatives through the SARRAH conference held over four days in September 2014;
- Distributed nine media releases to news outlets and received coverage on all occasions;
- Published six media articles in a range of print publications including the Tasmania Times, Medical Observer, Primary Health Care Research and Information Service and Sunday Telegraph;
- Conducted six media interviews and one press conference which was broadcast across a range of television and radio networks;
- Published 11 publications, 12 e-bulletins, 13 program e-newsletters, two special broadcasts and four board meeting communiques online through email and the SARRAH website;
- Expanded its social media presence from an audience of 750 and reach of 900 in June 2014 to 1294 and reach of 1373 in June 2015;
- Provided nine submissions responding to federal health policy discussions including the NDIS Quality and Safety Framework;
- Prepared copies of the SARRAH Annual Report, promotional material and resources for university open days; and
- Managed advertising campaigns to publicise the application process for receiving a scholarship in 2015-16.

In 2014-15 and continuing in 2015-16, SARRAH will consider adopting the following strategies to build its capacity to communicate and engage with the rural and remote allied health services sector:

- Engage a Communications Officer with experience working with rural and remote audiences;
- Seek feedback from members on the effectiveness of SARRAH communication strategies;
- Provide pro-active and hands on support to members; and
- Use a range of channels to communicate with members and non-members.

Future Strategic Direction

SARRAH must continually maintain its position as the peak body for rural and remote AHPs and in doing so, make sure that health policy directions include improved allied health services in rural and remote areas.

Australia's health care system must change and adapt to the health care needs of the Australian population. These changing needs include addressing the increasing burden of chronic diseases in the community, increased diagnoses of people experiencing from mental health illnesses, and the need to provide appropriate services for an ageing population.

There are several processes already underway which may result in much needed change including a Council of Australian Governments (COAG) led Reform of Federation which includes options to improve the efficiency of the health system. Also the establishment of a Primary Health Care Advisory Group to examine opportunities for the reform of primary health care in improving the management of people with complex and chronic disease by the Minister for Health, the Hon Susan Ley MP; and a comprehensive review of all items on the Medical Benefits Schedule. The introduction and national roll out of the National Disability Insurance Scheme over coming years will also impact on allied health services.

Australia needs a health workforce skilled in providing care in the community, and in establishing preventative health programs which meet local and national needs. AHPs have been identified as having a vital role to play in providing these services *(Philip, K. 2015. Allied health: untapped potential in the Australian health system. Australian Health Review. 39, 244-247)*.

SARRAH will play an important role in making sure decision makers understand the contribution of allied health particularly in rural and remote areas. SARRAH will strongly advocate for Governments to commit resources to research and evidence, workforce support, and to ensure health policy, programs and initiatives enable AHPs to contribute to better health outcomes for rural and remote Australians.

SARRAH's capacity to undertake this important work depends on funding. SARRAH currently receives funding from the Department of Health (DoH) to support our operations as a peak body.

Future Strategic Direction (cont')

In July 2015, the DoH announced a new programme, the Health Peak and Advisory Bodies Programme through which all peak bodies will be funded in future. SARRAH has applied for funding through a competitive tender process, the outcome of which will be known by the end of 2015.

In the 2015-16 Budget, the Australian Government announced that the NAHSSS will cease on 30 June 2015 and will be replaced by a consolidated Health Workforce Scholarship Programme. The administrator of this new programme will be selected through an open competitive tender process in late 2015. SARRAH's future involvement in scholarship administration is therefore uncertain. SARRAH will also seek opportunities to administer projects and programs that align with SARRAH's mission and strategic direction.

In this context, to ensure SARRAH remains an effective peak body, internally there will be a strong focus on diversifying income and increasing our capacity via increased membership numbers.

2014 SARRAH National Conference


SARRAH


THE SAMBA BLISSTAS
THE SAMBA BLISSTAS

2014 SARRAH National Conference Report

Kingscliff in New South Wales was the host of the 2014 SARRAH National Conference. Close to 200 delegates attended the Conference to hear from diverse speakers and to nurture networks with other rural and remote focused professionals.

Keynote speakers included Senator Deborah O'Neill, New South Wales Chair of the Senate Select Committee on Health; Comedian, Mr Luke Eshcombe; Associate Professor John Stevens; Professor Pat Dudgeon and Professor Susan Nancarrow.

At the 2014 SARRAH Conference, several themes under the headline "Surfs Up, Ride the Waves", gave delegates insights into:

- Developing healthy communities;
- Best practice in a challenging environment;
- Visionary future practice models;
- Developing and driving sustainability;
- Early career practitioner support; and
- Zones of conflict for allied health.

Networking was also a prominent feature of the Conference with delegates having the opportunity to meet and share experiences with colleagues from Australia and the world.

The Conference invited delegates to identify core priorities for improving patient and professional outcomes in rural and remote Australia. From these, delegates developed a set of Conference recommendations arising which have been incorporated into SARRAH's strategic priorities in 2014-15.

Delegates from a range of backgrounds were attracted to the 2014 Conference and included:

- Members of the vast range of rural and remote allied health workforce professions;
- Allied health students across a range of disciplines preparing for a future rural health career;
- Workforce policy and program planners, developers and funders supporting rural and remote allied health services; and
- Educators of Allied Health Professionals (AHPs) and consumers interested in the allied health sector.

SARRAH gratefully acknowledges the contribution of the Conference sponsors whose financial support helps SARRAH keep costs low for delegates.

Sponsors:

Health Education and Training Institute	Gold Sponsor
Westpac	Bronze Sponsor
Rural Health Workforce Australia	Bronze Sponsor
Medicare Local North Coast NSW	Bronze Sponsor
Queensland Government	Bronze Sponsor
National Rural Health Students Network	Bronze Sponsor
HESTA Industry Super Fund	Dinner Sponsor
Australian Rural Health Education Network	Student Meet and Greet Sponsor
Southern Cross University	Name Badge Sponsor

2014 SARRAH National Conference Report (cont')

Conference Evaluation

The Conference was rated highly by delegates, with 93% of those who completed the Conference evaluation indicating that they found the Conference to be relevant to their needs. Close 100% of respondents rated the Conference as either 'good' or 'very good'. Respondents felt the Conference:

- Provided excellent opportunities for networking with like-minded allied health and non-allied health professionals;
- Empowered delegates with the ability to form recommendations to shape the sector;
- Gave insights into supervision, service delivery models and transdisciplinary practice; and
- Shared innovative ideas to drive creative approaches in rural and remote service delivery.

Conference Recommendations

The delegates developed a set of Conference recommendations to improve the health and wellbeing of people living in rural and remote Australia, calling for the six key areas (below) to be given priority.

LEADERSHIP/INNOVATION

- All evidence-based allied health services should be included on the Medicare Benefits Schedule to prevent unnecessary hospitalisations and to encourage more private practice in rural areas;
- Ensure Australian hospitals have AHPs on duty 24/7, or with minimalist Emergency Department cover, to prevent escalating costs and patient decline overnight or on weekends;
- Prioritise rural health practitioners on the National Broadband Network roll out, as access to the internet/ WIFI will optimise patient care, and boost outreach services to remote Australians;
- Allow AHPs to refer directly to medical specialists to reduce patient suffering, long waitlists and to provide significant cost savings to the health budget;
- Train every Aboriginal Health Worker in Australia in oral care for children; and
- Provide funding for long-term clinical placements in rural areas, especially in pharmacy.

RURAL HEALTH POLICY AND ADVOCACY/ALLIED HEALTH EVIDENCE

- Develop a position paper on individualised funding models of care in remote areas – National Disability Insurance Scheme and aged care in particular;
- Monitor the impact of changes to higher education fees on rural allied health students;
- Advocate for the delivery of quality allied health services for people with a disability in rural and remote areas, including by lobbying the Federal Government to release reports already completed on the NDIS roll out; and
- Promote the Care Van, Sun Smiles, and Bright Eyes programs as successful preventative public health initiatives at a national level to improve eye and oral health of rural children.

MODELS OF CARE/SERVICE DELIVERY

- Conduct a meta-analysis of allied health models of care to identify the most efficacious models for Australia;
- Develop pathways, supported by academic and on-the-job training programs, which support expanded scope roles for AHPs in rural and remote communities;
- Expand the rural generalist model used in rural Queensland to other parts of Australia, with an emphasis on graduate positions and career progression; and
- Promote a framework of practice that supports collaboration, person-centred care, staff needs and discipline awareness.

EDUCATION AND TRAINING, RECRUITMENT AND RETENTION PROGRAMS FOR ALLIED HEALTH

- Conduct a follow-up study (at one, five and ten years) of those who have received SARRAH rural clinical placements and undergraduate scholarships to identify if these scholarships lead to rural and remote recruitment and retention;
- Develop formalised, standardised models of clinical placements across Australia;
- Develop an online training module for AHPs moving into management roles, and to familiarise managers who have little or no allied health knowledge or background;
- Provide training in how to work with allied health assistants;
- Create and implement an education package focusing on social media use in a rural or remote health context, particularly for new graduates or relocating clinicians; and
- Include telehealth competencies as part of undergraduate training.

COMMUNITY ENGAGEMENT

- SARRAH to lead a working group of health providers and patients to gather information on the challenges and opportunities of the NDIS rollout;
- Establish allied health research teams with the university sector to give a specific rural focus to future research priorities;
- Locate all allied health projects, programs and tools on a central site managed by SARRAH; and
- Form a "future careers" group within SARRAH to develop resources that deliver career awareness to early high school students. These packages could be delivered by AHPs when on outreach.

MEMBERSHIP

- Promote SARRAH membership to the disability sector as the NDIS rolls out across Australia, to other NGOs and to rural and remote AHPs in private practice;
- Encourage all first year allied health students and graduates to join SARRAH by targeting the university sector and key employers;
- Include conference registration in all scholarships to promote the benefits of membership.

Kate Scanlon Award 2014-15

During the 2014 SARRAH National Conference, SARRAH presented the 2014-15 Kate Scanlon Award. The Award was initiated in 2012 in memory of Kate Scanlon who was a NAHSSS recipient. Kate, aged 21, was killed in a train accident in 2011 while travelling with friends to volunteer at a local orphanage and school in a remote part of India. Kate came from a small town near Launceston Tasmania and was studying physiotherapy at Monash University. Kate planned to return home to practise physiotherapy once she completed her studies.

The Award provides Tasmanian undergraduate scholarship recipients with an opportunity to pursue a project or activity that will improve allied health services for Tasmanians.

In 2014 the Award was presented to Frances Aird. Frances who grew up in Devonport is studying a Physiotherapy degree at Monash University in Melbourne.

Frances plans to use her $5,000 prize to structure an adult fitness program based on darts, bowls, indoor cricket, football and Frisbee activities. She plans to follow this up with a team based competition to get local adults moving via cycling, walking and swimming.

Frances said targeted programs were needed due to the nature of farming communities.

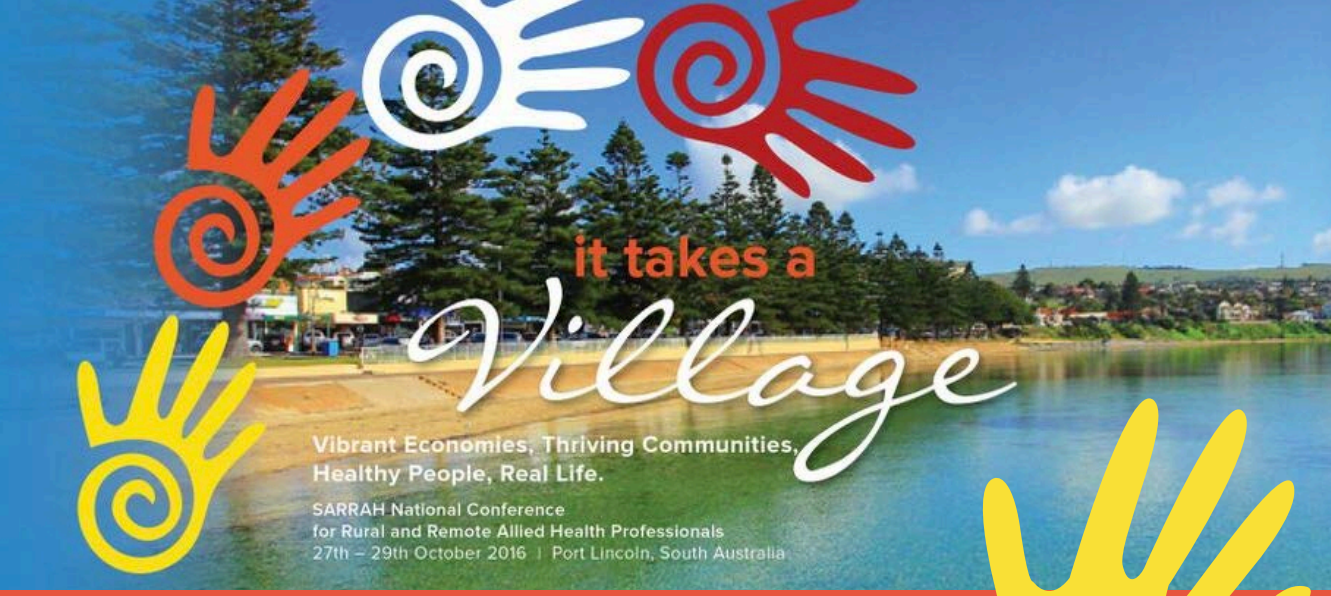
“The often long and irregular working hours of rural workers leaves little time for an exercise routine,” she said.

“Due to the remoteness of their location, farmers were unable to access gym and sporting facilities, unlike those living in urban areas.”

Frances will overcome this barrier by taking her fitness program to the farming communities in which she grew up.

“Most importantly Kate relished and created opportunities to share her story and University experiences with younger students, particular in the local Devonport area. Kate thrived on all aspects of University life; the academic challenge, the social scene, the Physiotherapy related opportunities that were possible. She felt students should be aware of the opportunities ‘out there’ and not be afraid to embrace them,” said Kate’s parents.

“Kate would be delighted with the thought that someone else was not only fulfilling their own dreams, but also encouraging other young people to take on the many opportunities life has to offer,” they said.



2016 SARRAH National Conference

The SARRAH 2016 Organising Committee invites SARRAH members, Allied Health Professionals and others interested in rural and remote health to attend the **2016 SARRAH National Conference**, 27 - 29 October 2016 in Port Lincoln, South Australia.

"It takes a village to raise a child" is a traditional African proverb and the theme for the 2016 SARRAH National Conference for Rural and Remote Allied Health Professionals.

What if our "child" is rural and remote health outcomes and thriving communities? In rural and remote life and work, our "village" has never been more important than it is today.

We live in a rapidly evolving environment and we are faced with a myriad of both challenges and opportunities each day. Navigating these changes can be daunting – collaboration, innovation, partnerships and supports are necessary to prepare our communities for a vibrant, sustainable future.

A 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.

It takes a village to have necessary tough conversations, to disagree and to problem solve in ways that are inclusive.

At the 2016 SARRAH National Conference, delegates will have the opportunity to explore how this village approach can be applied to rural and remote health outcomes.

Find out more about the 2016 SARRAH National Conference at **www.sarrahconference.com** and sign up to the mailing list to stay up to date.


T
VH
XUA
HTYO
VUAXT
HAYOUX

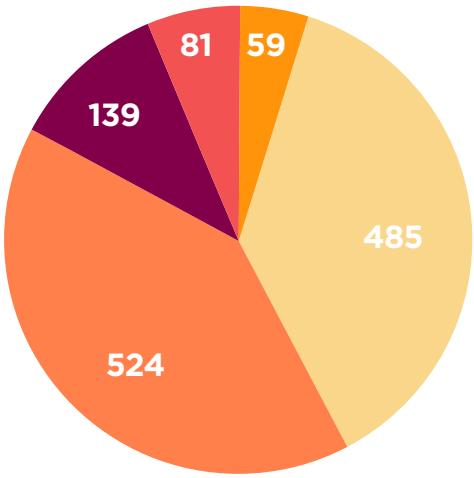
Program and Project Performance

Infographics

$11.2 million
total scholarship funding committed in 2014-15

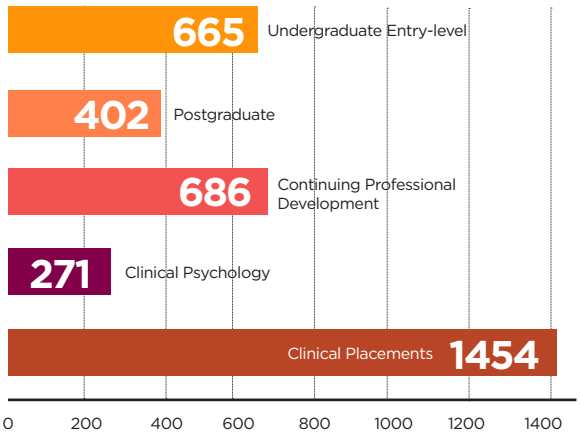
1,288
current scholars over five scholarship streams as at 30 June 2015

Distribution of Scholarships Awarded According to ASGC Classification



- ASGC-RA 1 59 / 4.6%
- ASGC-RA 2 485 / 37%
- ASGC-RA 3 524 / 41%
- ASGC-RA 4 139 / 11%
- ASGC-RA 5 81 / 6.4%

Demand for Scholarship Applications over 2014-15



Scholarship Awarded in 2014-15

261
Clinical Placements:
success rate 15%

75
Clinical Psychology:
success rate 28%

169
Continuing Professional Development:
success rate 24%

203
Postgraduate:
success rate 50%

166
Undergraduate Entry-level:
success rate 25%

Nursing And Allied Health Scholarship and Support Scheme (NAHSSS)

SARRAH has continued administering the allied health component of the NAHSSS. Funding is provided by the Australian Government Department of Health (DoH) with this national program supporting Allied Health Professionals (AHPs), and future professionals, to train and practice in geographic and clinical areas of need.

The objectives of the NAHSSS are to:

- Increase the health workforce by facilitating the entry of job seekers and youths interested in pursuing a career in allied health;
- Facilitate the continued professional development of AHPs; and
- Encourage the pursuit of a career in both geographic areas and professions where there are workforce shortages.

Scholarships are offered in the following areas:

- Clinical Placement: supporting students seeking to undertake a clinical placement in an eligible allied health profession and enrolled in an eligible allied health course;
- Clinical Psychology: supporting students applying to commence or already undertaking a clinical psychology course that provides the qualification required by the Psychology Board of Australia to become an endorsed clinical psychologist;
- Continuing Professional Development: supporting AHPs to attend short courses, conferences, non-award postgraduate modules and clinical placements;
- Postgraduate: supporting qualified AHPs who deliver clinical services in rural and remote Australia to study a formal postgraduate qualification at a recognised university or institution; and
- Undergraduate (Entry-Level): supporting students currently enrolled or intending to enrol in an undergraduate or entry level allied health course at an Australian university.

In 2014-15 scholarships were introduced that targeted areas of practice in primary care, aged care, mental health as well as people working in Indigenous health services and people from remote areas.

Certain criteria, including rurality, are used as ranking tools where scholarship places are oversubscribed. Rurality is determined by the use of the Australian Standard Geographic Classification – Remoteness Areas (ASGC-RA). The classification scheme, developed in 2001, allows quantitative comparisons between city and country Australia. The structure classifies remoteness by the physical distance of a location from the nearest urban centre based on population size. Eligible Classifications include:

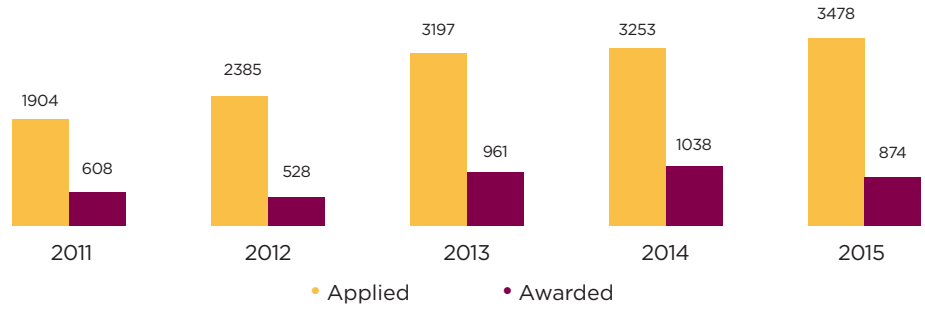
RA 1 Major Cities
RA 2 Inner Regional Australia
RA 3 Outer Regional Australia
RA 4 Remote Australia
RA 5 Very Remote Australia

Nursing And Allied Health Scholarship And Support Scheme (NAHSSS) (cont')

At the end of the 2014-15 financial year, the five scholarship streams had a total of 1,214 ongoing scholars. Since the inception of the NAHSSS scheme in 2010-11, more than 4000 AHPs and students have received support through the NAHSSS to improve the access to allied health services for rural and remote Australians.

Living and working in rural and remote areas brings additional costs for AHPs and students. The scholarships provide AHPs and students with funds to help meet the cost of course fees, living expenses, and travel and accommodation expenses. The financial support of the scholarships enables the recipients to continue, or pursue, a career in rural and remote Australia

Applications Received and Scholarships Awarded from 2011-2015



Applications Received and Scholarships Awarded In 2014 and 2015 by Academic Year

	2014			2015		
	Applied	Awarded	Success Rate %	Applied	Awarded	Success Rate %
Clinical Placements	1186	302	25	1454	261	18
Clinical Psychology	305	126	41	271	75	28
CPD	617	208	34	686	169	25
Postgraduate	359	194	54	402	203	50
Undergraduate	786	208	26	665	166	25
Total	**3253**	**1038**	**32**	**3478**	**874**	**25**

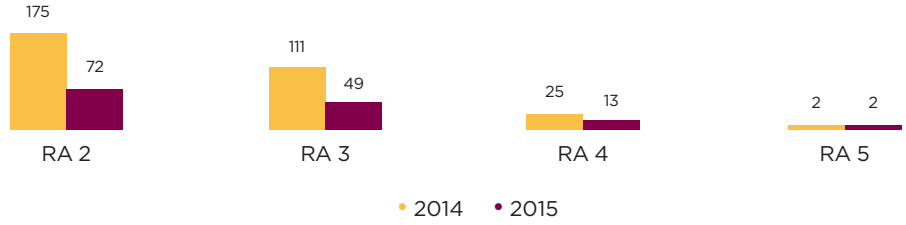
Aboriginal and Torres Strait Islander Applicants

SARRAH is committed to supporting and encouraging people who identify as Aboriginal and Torres Strait Islander (ATSI) background to apply for the NAHSSS scholarships. Since the NAHSSS commenced in 2010-11 the number of applications received from ATSI applicants has increased to 50 for the 2015 Scholarship round.

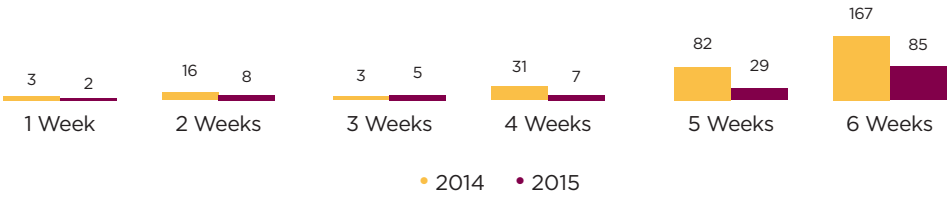
NAHSSS Clinical Placement Scholarship

Clinical placement scholarships are provided to students to support them to undertake a clinical placement in an eligible allied health profession. The scholarships are available for a clinical placement taken in a rural or remote area classification range ASGC-RA 2 to 5. Scholarship recipients are supported for placements of up to 6 weeks, and receive up to $11,000 in funding per placement. SARRAH has administered this scholarship since 2008 under various schemes.

Placement completed by ASGC-RA - 2014 (full years) and 2015 (Jan to June)



Placement completed by Number of weeks - 2014 (full year) and 2015 (January to June)



Note: 11 scholars had more than one placement over 2014-15 academic years.

Scholar Story
By Tracy Bauer

I was awarded the Clinical Psychology and Clinical Placement Scholarship. Living in the Regional town of Bundaberg, Queensland usually means extra travel because we are a town that is between major centres. I drove up to Rockhampton Wednesday, attended three days and then drove home. The learning and experience I gained while doing my course was phenomenal. I felt extremely privileged to have this opportunity. I can offer my clients a more comprehensive service and feel much more confident in the therapy I provide.

> **"My course was offered as an internal student in Rockhampton only. This is a 3-4 hour drive away. Without the financial support from the Scholarship attending would have been very challenging.**
> *— Tracy Bauer*

My Clinical placement was at the Kimberley Mental Health Service in Broome. The Broome mental health unit provides acute psychiatric inpatient care to people in the Kimberley and Pilbara.

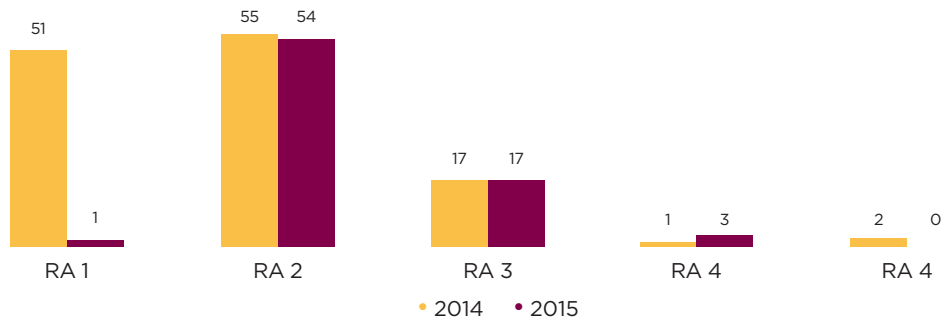
In Northern Western Australia, Aboriginal mental health staff are on hand to help bridge the gap, and support the cultural needs of patients. This was one of the most interesting work experiences I have had. To work with a larger population of Aboriginal people was professionally very beneficial. My Clinical supervisor Anne Cuypers and the other staff made me very welcome and offered lots of insights. I was also able to be a tourist on weekends and visited some outstandingly beautiful spots in the Kimberley including Windjana George National Park and the Prisoner Tree at Derby.

The SARRAH Scholarship enabled me to achieve some of my professional goals which may not have happened without their financial support.

NAHSSS Clinical Psychology Scholarship

The NAHSSS Clinical Psychology Scholarship supports students applying to commence or already undertaking a clinical psychology course that provides the qualification required by the Psychology Board of Australia to become an endorsed clinical psychologist. The scholarship provides funding for a maximum of two years of full time equivalent course of study at $15,000 per annum. The primary objective of the scholarship is to address the workforce shortages in areas of geographical and clinical need. SARRAH has administered this scholarship stream from 2010-11.

Scholarships awarded by Home ASGC-RA - 2014-15



Scholar Story
By Carly Sutherland

I moved from Birdwoodton Victoria, to Adelaide in 2009 to commence a Bachelor of Psychology (Honours) degree at the University of Adelaide. I had just turned 18 and had lived in Birdwoodton my whole life. Moving to the city really highlighted for me the inequality in accessing health services in rural areas.

To not be able to have a choice of service providers, get an appointment with a specialist within a few weeks (not months), and to not have to travel, made me realise how much we miss out in rural areas. This motivated me to complete my degree and try to do something about this inequality in my profession, psychology.

> **"The first four years of the undergraduate degree were difficult financially. I relied on my very supportive parents, odd tutoring and guitar teaching jobs, and working at a winery back home in the holidays. Being awarded the SARRAH Clinical Psychology Scholarship for the first year of the Combined PhD/ Master of Clinical Psychology program was a great help in allowing me to focus solely on my studies for the first time since leaving home.**
> *— Carly Sutherland*

The Scholarship has allowed me to take advantage of many professional opportunities. I am involved in the Australian Psychological Society Rural and Remote Interest Group (RRIG) as a national student representative, a role I continue to hold. As a student representative for RRIG I have been involved in a pilot survey investigating rural and remote psychology students' experiences in seeking postgraduate training in psychology.

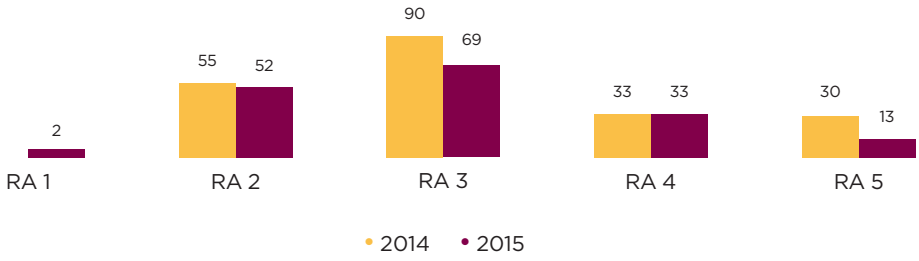
For my final PhD study I am conducting a survey of rural community members which aims to better understand rural community attitudes towards psychology, and the needs of rural people. Once finished I am hoping to work as a rural clinical psychologist continuing my research in the area of rural psychological service delivery. Particularly on how we can support and encourage psychologists to work and train in rural areas.

I am very grateful to SARRAH for the support I have received through the scholarship. I recognise the important contribution of the scholarships provided through SARRAH in supporting and growing the rural and remote psychology workforce.

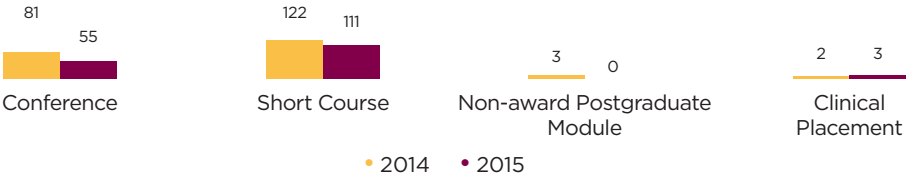
NAHSSS Continuing Professional Development Scholarship

The Continuing Professional Development (CPD) Scholarship supports AHPs to attend short courses, conferences, non-award postgraduate modules and clinical placements. Practicing AHPs who are providing clinical services in rural and remote areas can receive up to $3,000 to help them access CPD. SARRAH has administered the CPD Scholarships since 2003 under various schemes.

Scholarships awarded by Home ASGC-RA - 2014-15

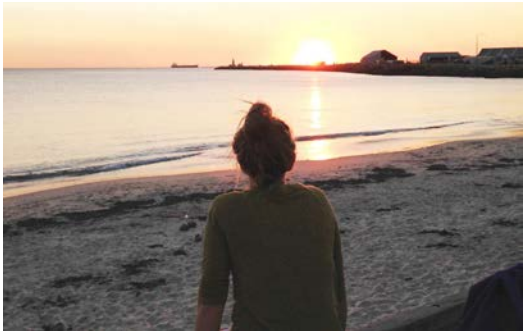


Scholarships awarded by CPD activity type - 2014-15



Scholar Story

By Stephanie Young



I've been working as a Community Dietitian with Townsville-Mackay Medicare Local for the last two years. This year I was fortunate enough to be awarded a NAHSSS Allied Health Continuing Professional Development scholarship to attend the Dietitians Association of Australia (DAA) 32nd National Conference in Perth, WA.

Since graduating in 2011, I have been working as a Dietitian in rural, regional and remote settings across Queensland. Thus, I hadn't yet had the opportunity to attend a DAA conference due to the associated costs.

My aim for the DAA conference was to learn as much new information as possible, and reconnect with existing and establish new networks and working relationships. I also had my sights set on watching the sun set over the Indian Ocean, an item not ticked off my bucket list.

Over the three day conference, I was exposed to a diverse and exciting range of research presentations, workshops, inspiring keynote speakers, valuable networking events, trade exhibits and more.

> **"A key take home message was, in today's world, we often have to opt out in order to make healthy and budget-friendly choices. Through continued strong leadership within our profession and collaboration with other sectors, we can work towards a future where we have to opt out to take the less healthy option.**
> *— Stephanie Young*

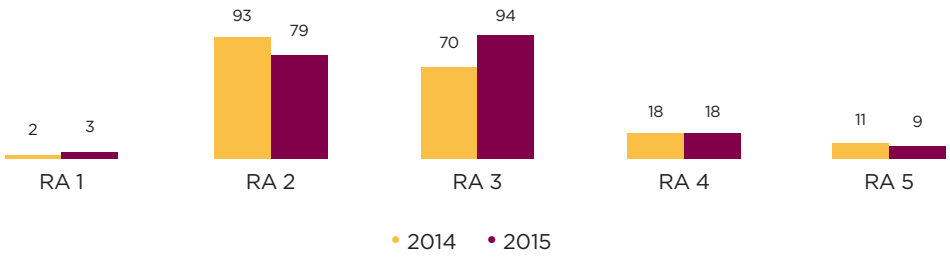
A personal highlight was the presentations on "Future gazing: Dietetics in 2050". A fundamental theme underpinning each speaker's projections and aspirations for the future was the leadership role that Dietitians need to continue to adopt in order to positively influence our world, including our environment, food supply and technology, to name a few.

Attending the conference has renewed my confidence to take on stronger leadership roles at work. I plan to apply the new knowledge and skills I've learned when liaising with stakeholders, and working with local communities. Facilitating family-based and Indigenous-specific nutrition education workshops, and establishing community gardens. I am excited to pass on the new knowledge, experiences and perspectives I've gained from attending the conference, to better equip clients and communities to support healthier living.

NAHSSS Postgraduate Scholarship

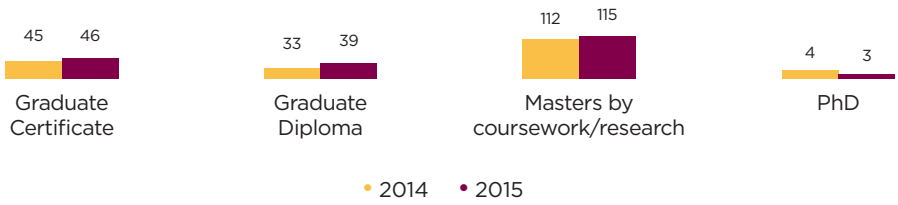
The NAHSSS Postgraduate Scholarship supports qualified AHPs including Aboriginal Health Workers (minimum qualification Cert IV) who deliver clinical services in rural and remote Australia to study a formal postgraduate qualification at a recognised university or institution. The scholarship provides funding for a maximum of two years of full time equivalent course of study at $15,000 per annum. SARRAH has administered the Postgraduate scholarship since 2003 under various schemes.

Scholarships awarded by ASGC-RA - 2014-15



Note: Two scholarships were awarded to ATSI applicants from ASGC-RA 1

Scholarships awarded by activity type - 2014 (full year) and 2015 (January to June)



Scholar Story
By Clare Wood

I was the recipient of a post graduate scholarship from SARRAH, and graduated from a Masters of Narrative Therapy and Community Work in 2015 from Melbourne University in partnership with the Dulwich Centre in Adelaide.

Receiving the scholarship from SARRAH enabled me to complete the masters whilst living in the remote East Kimberley region of Western Australia.

> **"It is incredibly expensive to fly out of remote areas and the organization I worked for had a limited budget for professional development. Without this financial assistance I would not have been able to manage the course fees as well as the cost of travel to attend study blocks.**
> *— Clare Wood*

Whilst studying Occupational Therapy at Curtin University, I had attended a rural placement in Kununurra during my final year. This introduced me to rural and remote mental health practice. I was fortunate to have an inspirational clinical supervisor and mentor and fellow Occupational Therapist, Jane Brown who gave me an insight into the innovation, flexibility and creativity required to work in a rural location. I returned to Kununurra in 2005 and have had a working relationship in the region since. My passion is working with remote children and families in remote Indigenous communities utilising skills in narrative therapy and Occupational Therapy.

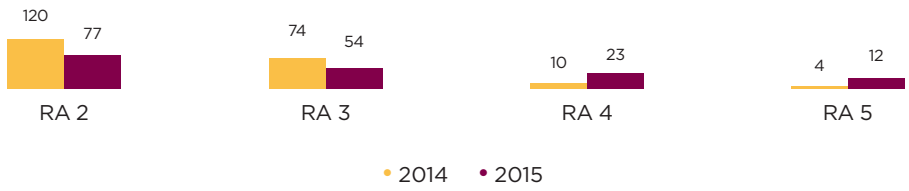
The masters in Narrative therapy gave me the opportunity to explore creative and innovative ways to respond to stories of distress and suicide and uncover stories of hope of survival in Indigenous communities.

Furthering education sustained my ability to work in a remote area as it's easy to become professionally isolated and for your work practice to stagnate in rural work setting. Being a member of an online learning community whilst at university meant I had a supportive professionally community whilst living in a remote place where opportunities for connection was limited. The SARRAH scholarship meant I was able to grow professionally and through University create networks of other professionals working in similar contexts across Australia and Internationally.

NAHSSS Undergraduate (Entry-Level) Scholarship

The NAHSSS Undergraduate (Entry-Level) scholarship is open to students currently enrolled or intending to enrol in an eligible allied health course that will result in the student becoming an AHP. These scholarships are targeted to students from a rural background. The scholarship provides funding up to $10,000 per annum for the duration of the study program. SARRAH has administered the Undergraduate (Entry-Level) scholarship since 2005 under various schemes.

Scholarships awarded by ASGC-RA - 2014-15



Scholar Story

By Sally Vilder

I am a final year Dietetics student at Charles Sturt University. Growing up in Kangaroo Valley, a small rural town on the South Coast of New South Wales, I was aware of the NAHSSS before I'd even applied for tertiary studies. In fact, it was my awareness of this scholarship that I thought I'd take a shot at university.

Education, although ever considered a blessing, was more difficult to attain for me than those who were a 2 minute walk to school in metropolitan areas. Having a single computer to be shared amongst 7 siblings within 12 years of each other was difficult, and much a lunchtime at school was sacrificed to the library, where (mostly) unrivalled access to computers allowed for homework completion.

Since my first year of university, I've been volunteering at soup kitchens, assisting in healthy lunch box campaigns, and educating parents on healthy foods. I also taught at Nutrition and health education days at the university, and more recently, ran a healthy weight loss program for Aboriginal members of the community via Riverina Medical and Dental Aboriginal Corporation.

So, to the crunch; how has this scholarship helped me? Well, I've now got two placement uniforms ($80 each); two invaluable clinical nutrition textbooks all to myself (>$300 worth); a fully functional laptop ($350 repair); enough money for fuel to get me between placements and home (Bendigo (Vic), Wagga Wagga (NSW), Portland (Vic), and Canberra (ACT) and to pay for my accommodation at each site (>$150/wk); enough funds to buy the good pens, folders, and notepads (I know that's miscellaneous, but I promise it's helped a lot), and lastly, security – something that's been so psychologically important for me this year. I don't think myself materialistic, but money is really something that plays on your mind and can get you down when it's lacking in your life.

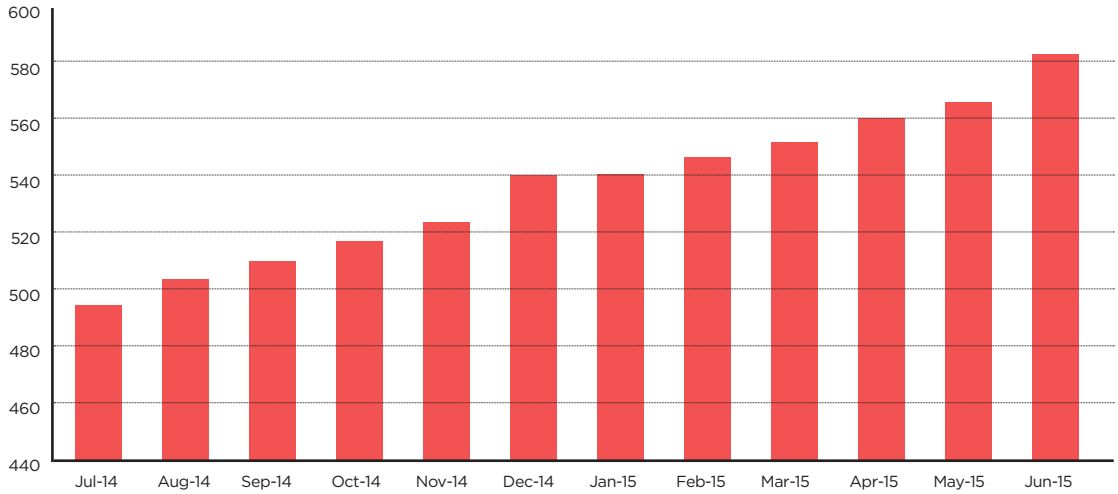
I cannot thank you enough for your support this year, please keep supporting rural students! Please keep financing our future.

National Rural and Remote Support Service (NRRSS)

Infographics

NRRSS Membership Profile in 2014-15

NRRSS membership increased from **494** in July 2014 to **584** in June 2015



NRRSS Activity Performance Indicators

Rural and Remote Providers Accessing SARRAH Strategies

access to NRRSS and SARRAH resources were provided to members of SARRAH and the NRRSS living and operating in rural and remote Australia including **584** members of the NRRSS. This represents a significant percentage of the rural and remote allied health workforce

Increasing in Service Coverage in Rural and Remote Australia

43.75% increase in **early intervention allied health professionals** registered with the DSS across Australia

70.88% increase in **early intervention allied health professionals** registered with the DSS in regional zones ASGC-RA 3 to ASGC-RA 5

Project Statistics

1474 flyers distributed

2 surveys circulated

3 webinars produced

10 written articles on a range of topics

205 members engaged regularly through Facebook group

309 members contacted directly

National Rural and Remote Support Service (NRRSS)

The NRRSS developed and delivered information to allied health early intervention service providers. It also supported the delivery of allied health services in rural and remote Australia and assisted with registration to the Early Intervention Service Provider Panel that is administered by the Australian Government Department of Social Services (DSS).

Early Intervention Panel Providers deliver support to children with a disability or developmental delay who are eligible to receive funding by the Better Start for Children with a Disability (Better Start) initiative or Helping Children with Autism (HCWA) package.

The NRRSS received $450,000 in funding from the DSS over 2 years to administer the program and since its establishment has achieved the following key project outcomes:

- Established and upgraded the website used to deliver information for the benefit of allied health service providers registered as a member with the NRRSS;
- Formed an Expert Reference Group (ERG) that provided input into NRRSS activities. The ERG included broad representation from across the sector and included private providers, professional organisations and agency representatives;
- Conducted a short series of Webinars into topics that support the development of rural and remote services;
- Delivered hands on support for service providers seeking registration with the DSS Early Intervention Service Provider Panel including telephone support, instructional guides and review of draft applications;
- Implemented a communication campaign including phone calls and bulk mail outs to recruit members to the project;
- Targeted research campaigns focused on gathering information for research purposes, mapping service delivery and adding outreach locations to a service called My Outreach Ally;
- Established a mentoring program which offered an online learning package and facilitated mentoring partnerships;
- Collected data through quantitative and qualitative research methods that identified the key barriers to registering with the DSS early intervention provider panel and gaps in rural and remote service delivery;
- Conducted research into a range of service models that could potentially be applied to the delivery of early intervention services in rural and remote communities; and
- Provided services such as professional forums, professional development opportunities, industry information and a monthly newsletter.

At the conclusion of the program the NRRSS had approximately 584 members and contributed to a 70.88% increase in AHPs registered as a member of the Better Start and HCWA early intervention panels administered by DSS who operate in regions ASGC-RA3 to ASGC-RA 5. In addition, the NRRSS has produced 10 articles and 4 podcasts that will provide an ongoing benefit to AHPs via the SARRAH website.

Financial Management

Financial Management

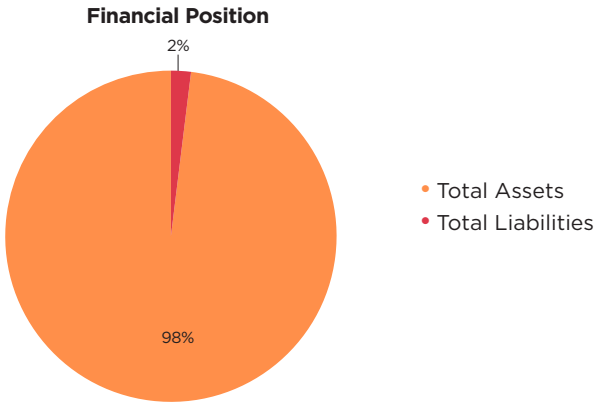
An overview of SARRAH's financial position is presented in the charts below.

Statement of Financial Position as at 30 June 2015

ASSETS	2015 ($)	2014 ($)
CURRENT ASSETS	15,787,745	16,557,639
NON-CURRENT ASSETS	91,002	97,154
TOTAL ASSETS	**15,878,747**	**16,654,793**

LIABILITIES	2015 ($)	2014 ($)
CURRENT LIABILITIES	250,772	251,251
NON-CURRENT LIABILITIES	21,869	56,519
TOTAL LIABILITIES	**272,641**	**307,770**
NET ASSETS	**15,606,106**	**16,347,023**

SARRAH had a cash surplus of $15.70 million of which 99% is committed to scholarships that have been granted and for which future payments are required.

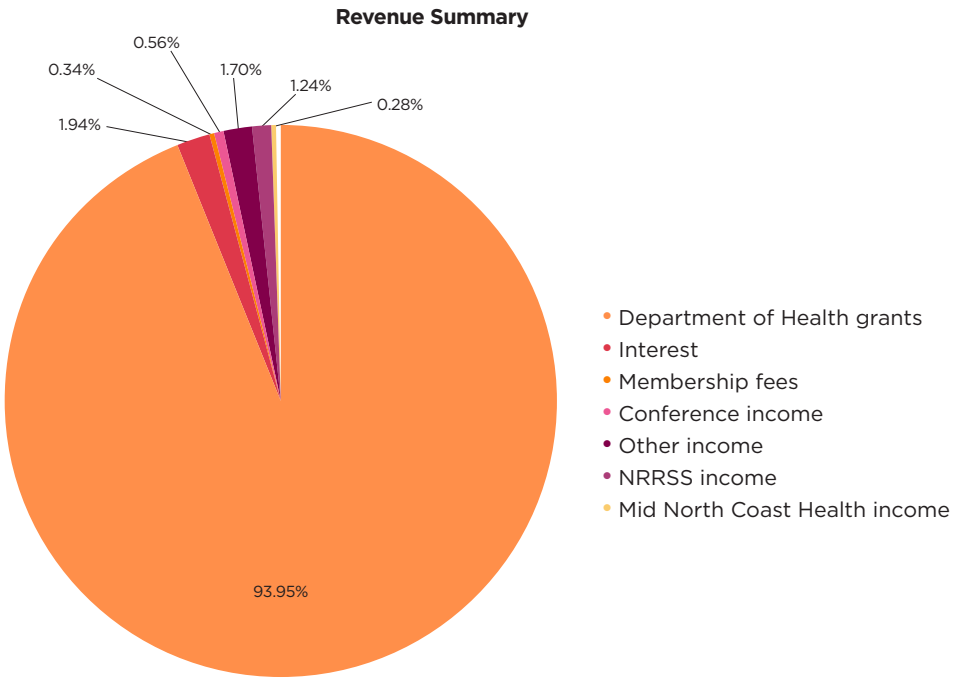


Revenue to 30 June 2015

SARRAH received revenue of $12.13 million for 2014-15 and the next table represents the actual results through to 30 June 2015.

Revenue	2015 ($)	2014 ($)
Department of Health Grants	11,401,264	12,850,054
Interest	235,010	216,149
Membership fees	41,584	26,073
Conference income	67,617	10,000
Other income	205,939	188,614
RHCE2 income	-	5,950
NRRSS income	150,000	150,000
Mid North Coast Health income	34,173	-
Total Revenue	**12,135,587**	**13,446,840**

Revenue summary



Financial Management (cont')

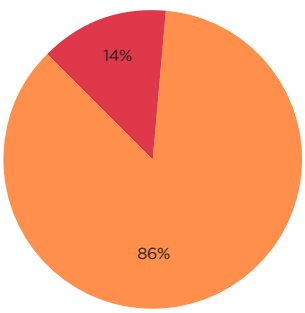
Expenses to 30 June 2015

SARRAH's expenses were $12.87 million during 2014-15 and the table below presents actual results through to 30 June 2014.

Expenses	2015 ($)	2014 ($)
Employee benefits expense	1,168,090	1,070,053
Depreciation expense	23,365	21,818
Rental expense	102,032	134,030
Scholarship payments	11,051,878	10,399,934
Conference expenses	28,462	38,230
Other expenses	475,293	713,409
Mid North Coast Health expenses	27,384	-
Total Expenses	**12,876,504**	**12,377,474**

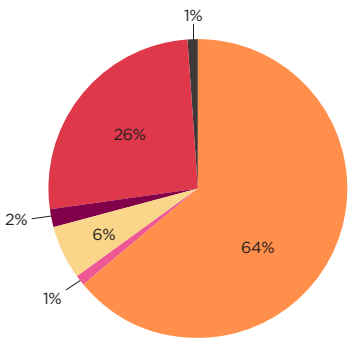
Expenses summary

All Expenses



- Scholarship payments
- Expenses excluding scholarship payments

Expenses excluding scholarship payments



- Employee benefits expense
- Depreciation expense
- Rental expense
- Conference expense
- Other expense
- Mid North Coast Health expense

Services for Australian Rural and Remote Allied Health Incorporated (SARRAH)

ABN 92 088 913 517

Financial Report for the Year Ended 30 June 2015

STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME
FOR THE YEAR ENDED 30 JUNE 2015

	Note	2015	2014
		$	$
Revenue	2	12,135,587	13,446,840
Employee provisions expense		(1,168,090)	(1,070,053)
Depreciation expense		(23,365)	(21,818)
Rental expense	3	(102,032)	(134,030)
Scholarship payments	3	(11,051,878)	(10,399,934)
Conference expenses	3	(28,462)	(38,230)
Mid North Coast Health expenses		(27,384)	-
Other expenses	3	(475,293)	(713,409)
Net current year (deficit) / surplus		(740,917)	1,069,366
Other comprehensive income		-	-
Total comprehensive income for the year		(740,917)	1,069,366

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2015

	Note	2015 $	2014 $
ASSETS			
CURRENT ASSETS			
Cash and cash equivalents	5	15,669,665	16,478,747
Trade and other receivables	6	96,572	26,686
Other current assets	7	21,508	52,206
TOTAL CURRENT ASSETS		15,787,745	16,557,639
NON-CURRENT ASSETS			
Plant and equipment	8	91,002	97,154
TOTAL NON-CURRENT ASSETS		91,002	97,154
TOTAL ASSETS		15,878,747	16,654,793
LIABILITIES			
CURRENT LIABILITIES			
Trade and other payables	9	196,499	222,025
Provisions	10	49,996	24,949
Lease liability	11	4,277	4,277
TOTAL CURRENT LIABILITIES		250,772	251,251
NON-CURRENT LIABILITIES			
Provisions	10	11,890	42,263
Lease liability	11	9,979	14,256
TOTAL NON-CURRENT LIABILITIES		21,869	56,519
TOTAL LIABILITIES		272,641	307,770
NET ASSETS		15,606,106	16,347,023
EQUITY			
Retained surplus		15,606,106	16,347,023
TOTAL EQUITY		15,606,106	16,347,023

STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2015

	Retained Surplus $	Total $
Balance at 1 July 2013	15,277,657	15,277,657
Comprehensive income		
Net surplus for the year	1,069,366	1,069,366
Balance at 30 June 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

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2015

	Note	2015 $	2014 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipts from government, members and customers		12,273,480	13,622,444
Interest received		235,010	216,149
Net GST (paid)		(346,360)	(318,241)
Payments to suppliers and employees		(12,949,722)	(12,517,858)
Net cash (used by) / provided from operating activities	16	(787,592)	1,082,494
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of plant and equipment		(17,213)	(51,385)
Net cash used in investing activities		(17,213)	(51,385)
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of borrowings		(4,277)	(2,851)
Net cash used in financing activities		(4,277)	(2,851)
Net (decrease) / increase in cash held		(809,082)	1,028,258
Cash and cash equivalents at beginning of financial year		16,478,747	15,450,489
Cash and cash equivalents at end of financial year	5	15,669,665	16,478,747

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The financial statements were authorised for issue on 4 September 2015 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 1987. 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*.

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.

d. **Financial instruments (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 render 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 remeasurement 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.

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.

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.

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2015

NOTE 2: REVENUE	2015 $	2014 $
Revenue		
Department of Health Grants	11,401,264	12,850,054
Interest	235,010	216,149
Membership fees	41,584	26,073
Conference income	67,617	10,000
Other income	205,939	188,614
RHCE2 income	-	5,950
NRRSS income	150,000	150,000
Mid North Coast Health income	34,173	-
Total revenue	12,135,587	13,446,840

NOTE 3: SURPLUS FOR THE YEAR	2015 $	2014 $
a. **Expenses**		
Rental expense on operating leases:	(102,032)	(134,030)
b. **Significant Revenue and Expenses**		
The following significant revenue and expense items are relevant in explaining the financial performance:		
Department of Health	11,401,264	12,850,054
Employee benefits expense	(1,168,090)	(1,070,053)
Scholarship payments	(11,051,878)	(10,399,934)
Conference expenses	(28,462)	(38,230)
Other operating expenses	(475,293)	(713,409)

NOTE 4: AUDITORS' REMUNERATION	2015 $	2014 $
Remuneration of the auditor of the association for:		
- Auditing the financial report	8,400	8,182
- Other services	8,750	2,727
Total remuneration	17,150	10,909

NOTE 5: CASH AND CASH EQUIVALENTS	Note	2015 $	2014 $
Cash at bank and on hand		15,669,665	16,478,747
	17	15,669,665	16,478,747

The effective interest rate on short-term bank deposits was 2.74% (2014: 2.83%)

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	15,669,667	16,478,747

Approximately 99% of the cash funds held as at 30 June 2015, relates to scholarships that have been granted and for which future payments are required.

NOTE 6: TRADE AND OTHER RECEIVABLES	Note	2015 $	2014 $
CURRENT			
Trade and other receivables		6,800	797
GST receivable		89,772	25,889
Total current trade and other receivables	17	96,572	26,686

NOTE 7: OTHER CURRENT ASSETS	2015 $	2014 $
CURRENT		
Prepayments	21,508	52,206

NOTE 8: PLANT AND EQUIPMENT	2015 $	2014 $
Office equipment:		
At cost	156,978	139,765
Accumulated depreciation	(119,745)	(109,690)
	37,233	30,075
Office furniture:		
At cost	98,755	98,755
Accumulated depreciation	(44,986)	(31,676)
	53,769	67,079
Total plant and equipment	91,002	97,154

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 2014	30,075	67,079	97,154
Additions	17,213	-	17,213
Depreciation expense	(10,055)	(13,310)	(23,365)
Carrying amount at 30 June 2015	37,233	53,769	91,002

NOTE 9: ACCOUNTS PAYABLE AND OTHER PAYABLES		2015 $	2014 $
CURRENT			
Trade payables		23,166	23,613
Wages and superannuation accrual		56,971	56,543
Provision for annual leave		58,497	65,349
Income in advance		3,988	52,410
Other payables		53,877	24,110
Total trade and other payables		196,499	222,025
a. Financial liabilities at amortised cost classified as accounts payable and other payables			
Accounts payable and other payables		196,499	222,025
Less wages and superannuation accrual		(56,971)	(56,543)
Less provision for annual leave		(58,497)	(65,349)
Less income received in advance		(3,988)	(52,410)
Less other payables		(53,877)	(24,110)
Financial liabilities as trade and other payables	17	23,166	23,613

NOTE 10: PROVISIONS	2015 $	2014 $
CURRENT		
Current long service leave provision	49,996	24,949
NON-CURRENT		
Non-current long service leave provision	11,890	42,263
Total provisions	61,886	67,212
Analysis of long service leave provision		
Opening balance at 1 July 2014		67,212
Additional provisions		3,388
Amounts used		(8,734)
Total provisions		61,886

NOTE 11: LEASE LIABILITY	2015 $	2014 $
Current	4,277	4,277
Non-current	9,979	14,256
Total lease liability	14,256	18,533

NOTE 12: CAPITAL AND LEASING COMMITMENTS		2015 $	2014 $
a.	**Finance Lease Commitment**		
	Payable – minimum lease payments:		
	– not later than 12 months	4,277	4,277
	– between 12 months and five years	9,979	14,256
	Minimum lease payments	14,256	18,533

The finance lease for the photocopier, which commenced in the 2014 financial year, is a 60 month lease. 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	115,454	115,454
	– between 12 months and five years	29,144	365,590
	Total operating lease commitments	144,598	481,044

The property lease commitment is a non-cancellable operating lease with a three-year term, 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.

NOTE 13: CONTINGENT LIABILITIES AND CONTINGENT ASSETS

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

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, including future funding for scholarships. It is not anticipated that these decisions will be made until the last quarter of the 2016 financial year end.

NOTE 15: RELATED PARTY TRANSACTIONS	2015 $	2014 $
a. Key Management Personnel		
Any person(s) having authority and responsibility for planning, directing and controlling the activities of the association, directly or indirectly, including its committee members, is considered key management personnel.		
Key management personnel compensation:		
- Short-term benefits	182,956	182,324
- Post-employment benefits	13,479	16,865
Total key management personnel compensation	196,435	199,189

b. Other related party transactions

Scholarships paid to related parties

- Daniel Mahony ($15000 committed in 2012 and $1875 paid in 2014-15)
- Kathryn Fitzgerald ($22,500 committed in 2012 and $7,500 paid in 2014-15)

Transactions between related parties are on normal scholarship terms and under conditions no more favourable than those available to other persons unless otherwise stated. Although SARRAH administers the NAHSSS scholarships, scholarship applications are externally assessed and neither the SARRAH Secretariat nor the Board are involved in the selection process.

NOTE 16: CASH FLOW INFORMATION	2015 $	2014 $
Reconciliation of cash flow from operations with profit		
(Deficit) / Surplus	(740,917)	1,069,366
Cash flows excluded from profit attributable to operating activities		
Non-cash flows in profit:		
- depreciation expense	23,365	21,818
Changes in assets and liabilities		
- (increase) in trade and other receivables	(69,886)	(15,862)
- Decrease / (increase) in other assets	30,698	(9,790)
- Increase in trade and other payables	22,896	6,331
- (decrease) in other liabilities	(48,422)	(7,590)
- (decrease) / increase in provisions	(5,326)	18,221
Total	(787,592)	1,082,494

NOTE 17: 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	2015 $	2014 $
Financial assets			
Cash and cash equivalents	5	15,669,665	16,478,747
Trade and other receivables	6	96,572	26,686
Total financial assets		15,766,237	16,505,433
Financial liabilities			
Financial liabilities at amortised cost:			
– Trade and other payables	9	23,166	23,613
– Lease liability	11	14,256	18,533
Total financial liabilities		37,422	42,146

NOTE 18: 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

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2015

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 Inc during and at the end of the financial year of the association ending on 30 June 2015.
2. At the date of this statement, there are reasonable grounds go believe that Services for Australian Rural and Remote Allied Health Inc 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

Ruth Chalk

Dated this 4th day of September 2015

bellchambers barrett

p (+61 2) 6140 5800
e admin@bellchambersbarrett.com.au
Level 1, 33 Torrens Street,
Braddon ACT 2612
PO Box 5115, Braddon ACT 2612
ABN 83 600 364 896
bellchambersbarrett.com.au

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 2015, 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 committee on the annual statements giving a true and fair view of the financial position of the association.

Committee's Responsibility for the Financial Report

The committee of the association is 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 1987* and for such internal control as the committee determines 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 committee, 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.

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 1987*, including:

(i) giving a true and fair view of the association's financial position as at 30 June 2015 and of its performance for the year ended on that date; and

(ii) complying with Australian Accounting Standards – Reduced Disclosure Requirements.

Shane Bellchambers, FCA
Registered Company Auditor
BellchambersBarrett

Canberra, ACT
Dated this 4th day of September 2015

Appendices

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 the following submissions were developed:

- **Submission to the Senate Select Committee into Health:** To inquire and report on health policy, administration and expenditure
- **Submission to the Senate Standing Committee on Community Affairs – References Committee:** The prevalence of different types of speech, language and communication disorders and speech pathology services in Australia
- **Submission to the Treasurer:** Federal Budget Submission 2015-16
- **Submission to the South Australian Government:** On the Transforming Health Proposals Paper
- **Submission to the Department of Health:** Public consultation process – National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families
- **Submission to the Australian National University:** Supporting primary health care research – Future directions' discussion paper
- **Submission to the Council of Australian Governments (COAG) Disability Reform Council:** Consultation paper on quality and safeguarding in the National Disability Insurance Scheme (NDIS)
- **Submission to the Tasmanian Government:** One State, One Health System, Better Outcomes – Draft White Paper
- **Submission to the Department of Health:** Submission to National Diabetes Strategy Framework Consultation

Appendix B
Meetings and Forums

Internal

- **SARRAH Board:** 3/7/2014, 26/8/2014, 2/12/2014, 24/2/2015 and 30/6/2015;
- **Audit Committee:** 25/7/2014, 15/8/2014, 23/1/2015, 13/2/2015, 20/3/2015, 16/4/2015, 28/5/2015 and 19/6/2015;
- **Advisory Committee:** 14/8/2014, 27/11/2014 and 4/6/2015;
- **Conference Organising Committee:** 7/7/2014, 14/7/2014, 18/8/2014, 1/9/2014, 8/9/2014, 13/1/2015, 11/3/2015, 22/5/2015, 16/6/2015 and 18/6/2015;
- **Membership Recruitment and Marketing Sub-committee:** 21/7/2014 and 11/8/2014;
- **Secretariat Staff:** 12/8/2014, 9/9/2014, 14/10/2014, 31/10/2014, 3/11/2014, 10/2/2015, 15/4/2015, 13/5/2015, 3/6/2015 and 17/6/2015;
- **SARRAH Managers:** 9/2/2015, 1/5/2015, 15/5/2015, 19/5/2015, 29/5/2015 and 12/6/2015;
- **Northern Territory SARRAH Members:** 28/8/2014, 30/10/2014, 11/12/2014, 27/2/2015 17/4/2015 and 19/6/2015;
- **SARRAH Board Interviews:** 18/3/2015 and 19/3/2015; and
- **SARRAH/Novartis Project:** 26/5/2015

Parliamentarians and Committees

- **Senate Community Affairs Legislation Committee Hearing - Private Health Insurance (GP Services Bill):** 20/8/2014;
- **Cathy McGowan's MP Senior Advisor (Canberra):** 3/9/2014;
- **Nick Champion MP (Canberra):** 3/9/2014;
- **Parliamentary Friendship Group for Rural and Remote Allied Health (Canberra):** 4/9/2014 and 4/3/2015;
- **Parliamentary Friends of Carers Group Meeting held (Canberra):** 24/9/2014;
- **Senate Select Committee on Health Public Hearing (Melbourne):** 8/10/2014;
- **Minister Morrison's Senior Advisor (Canberra):** 3/2/2015;
- **Senator Richard Di Natale (Canberra):** 4/3/2015;
- **GP NSW delegation with Federal Parliamentarians (Canberra):** 4/3/2015;
- **Australian Labour Party - Regional Health Roundtable Forum (Canberra):** 12/5/2015;
- **Federal Budget Briefing (Canberra):** 12/5/2015; and
- **Senate Forum at National Press Club (Canberra):** 24/6/2015.

Appendix B (cont')
Meetings and Forums

Australian Government Departments and Authorities

- **National Allied Health Advisory Committee Meeting with Chief Allied Health Officer in Canberra:** 26/3/2015;
- **Department of Health - Allied Health Scholarships meeting:** 4/7/2014;
- **Department of Health - Establishment of the Primary Health Networks meeting:** 7/7/2014;
- **Department of Health - Patient Contributions for GP, Pathology and Diagnostic Imaging Services (Canberra):** 24/7/2014;
- **Department of Health Review of the Personally Controlled Electronic Health Record (Brisbane):** 5/8/2014;
- **Department of Veterans' Affairs Allied Health Advisory Committee:** 21/7/2014;
- **Department of Human Services Medicare Stakeholder Consultative Group (Canberra):** 5/11/2014 and 17/2/2015;
- **Information Sessions on New Grant Agreements and Department of Social Services Data Exchange (Canberra):** 26/11/2014;
- **National Disability Insurance Agency Meeting:** 28/11/2014 and 11/5/2015;
- **National Disability Insurance Agency Rural & Remote Reference Group (Adelaide):** 12/12/2014;
- **Department of Health Workshop - Allied Health Priorities in Canberra:** 5/3/2015;
- **Department of Health Workshop - Allied Health Priorities workshop (Melbourne):** 7/4/2015;
- **NDIS Working Group - Safety and Quality Submission:** 13/4/2015;
- **NDIS Live Streaming Event in Wagga Wagga:** 21/4/2015; and
- **Department of Health (Canberra):** 26/5/2015 and 12/6/2015.

Medicare Locals

- **Country South SA Medicare Local Nominations and Appraisal Committee:** 13/8/2014;
- **Sunshine Coast Medicare Local Members' meeting:** 14/8/2014;
- **Western NSW Medicare Local Annual General Meeting:** 15/10/2014;
- **Country South Australia Medicare Local Annual General Meeting (Adelaide):** 22/10/2014; and
- **Country South South Australia Medicare Local Members Forum:** 3/12/2014.

State and Territory

- **National Disability Services Forum and Workshop (Darwin):** 24/7/2014;
- **Queensland Primary Health Care Network meeting:** 20/8/2014, 19/11/2014 and 18/5/2015;
- **Aboriginal Student Network meeting (Lismore):** 15/9/2014; and
- **Aboriginal Medical Service Alliance NT (Darwin):** 18/5/2015.

Other Meetings and Forums

- **Social Determinants of Health events (Canberra):** 14/7/2014, 20/8/2014 and 7/5/2015;
- **Australian Health Care Reform Alliance National Summit (Canberra):** 15/7/2014 and 16/7/2014;
- **Clinical Placement Scholarships Presentation to University of Tasmania:** 16/7/2014;
- **Shared entry-level qualifying statements for the Physiotherapy Profession in Australia and New Zealand Project Workshop:** 17/7/2014;
- **Dental Relocation and Infrastructure Scheme Steering Committee meeting:** 21/7/2014;
- **NRRSS Expert Reference Group:** 1/8/2014, 30/10/2014 and 27/3/2015;
- **Australian Charities and Not-for-Profits Commission session (Canberra):** 28/8/2014;
- **Australian Allied Health Forum:** 1/9/2014, 1/12/2014, 25/3/2015 and 11/6/2015;
- **Australian Allied Health Summit:** 1/9/2014 - 2/9/2014;
- **Climate and Health Alliance:** 5/9/2014;
- **Community Council for Australia events:** 8/9/2014, 16/9/2014 and 8/3/2015;
- **Presentation to Occupational Therapy and Physiotherapy Masters Students Flinders University:** 8/9/2014;
- **National Rural Health Alliance Council Fest:** 19/9/2014 - 23/9/2014;
- **Australian Orthotic and Prosthetic Association 2014 Congress held in Melbourne:** 9/10/2014 - 10/10/2014;
- **NAHSSS Continuing Professional Development and Postgraduate Assessment:** 14/10/2014; and
- **NAHSSS Clinical Psychology Scholarship Assessment:** 17/10/2014.
- **NSW/ACT Careers Advisors Expo (Sydney):** 24/10/2014;
- **ANU Research Project Presentation (Canberra):** 24/10/2014;

Appendix B (cont')
Meetings and Forums

- **NRRSS Webinars:** 6/11/2014;
- **NAHSSS Reference Group:** 6/11/2014 and 4/6/2015;
- **Australian Sports Foundation (Canberra):** 13/11/2014;
- **Australian National University Internship Forum (Canberra):** 21/11/2014;
- **Pharmacy Guild of Australia Annual Dinner (Canberra):** 24/11/2014;
- **Australian Diabetes Educators CDE of the Year Awards Program (Canberra):** 25/11/2014;
- **Presentation of SARRAH Award at Indigenous Allied Health Australia Event (Canberra):** 25/11/2014;
- **National Rural Health Alliance Council:** 1/12/2014, 23/2/2015 and 4/5/2015;
- **Regional Australian Institute Meeting (Canberra):** 26/11/2014;
- **Australian Labor Party 'regional health policy planning day' (Canberra):** 5/12/2014;
- **Public Health Association of Australia (Canberra):** 10/12/2014 and 22/6/2015;
- **Associations Forum (Canberra):** 10/12/2014;
- **Climate and Health Alliance:** 11/2/2015;
- **Remote Area Health Corp Function (Canberra):** 24/2/2014;
- **General Practice NSW Primary Health Care Leaders Forum (Sydney):** 25/2/2015;
- **Royal Far West (Canberra):** 3/3/2015;
- **Lowijta Institute launch at Parliament House (Canberra):** 5/3/2015;
- **Royal Flying Doctor Service function (Canberra):** 5/3/2015;
- **Bush Service Support External Roundtable:** 12/3/2015;
- **Australian National University Internship Program 21st Anniversary Dinner at Parliament House (Canberra):** 17/3/2015;
- **CRANAplus (Canberra):** 9/3/2015;
- **Early Childhood Intervention Australia (Canberra):** 23/4/2015 and 20/5/2015;
- **Greater Northern Australia Regional Training Network:** 1/5/2015;
- **Rural Health Workforce Australia meeting (Canberra):** 8/5/2015;
- **NT Health Familiarisation Visit to Alice Springs:** 14/5/2015 to 17/5/2015;
- **Palliative Care Australia Event (Canberra):** 26/5/2015;
- **National Primary Health Care Partnership meeting (Canberra):** 10/6/2015.

Appendix C
Media Releases, Media Coverage and Articles

Media Releases

- **Fears of university fee hikes expected to boost scholarship demand:** 1/9/2014;
- **Health Conference tackles the service deficit in rural Australia:** 10/9/14;
- **Active Tasmanian physiotherapy student wins rural health award:** 19/9/14;
- **Last chance for financial help to attend university in 2015:** 14/10/2014;
- **Demand for health scholarships outstrips supply:** 22/12/2014;
- **Report reveals rural children miss out on early intervention:** 4/3/2015;
- **Forgotten health providers are key to healing patients and budgets:** 4/3/2015;
- **Government's health budget needs rural proofing:** 12/05/15; and
- **National Obesity Prevention Network first victim in cuts to Flexible Health Funds:** 29/06/15.

Media Coverage

- **Media interview on SARRAH Conference with Rod Wellington broadcast on ABC New England North West Mornings:** 17/9/14.
- **Media interview on SARRAH Scholarships with Rod Wellington broadcast by various outlets during December** 2014.

Articles

- **Clinical Psychology scholarships tackle barriers to rural practice;**
- **ANU Intern Program reports informed articles that appeared in Tasmania Times, Medical Observer, Pharmacy Daily, and PHCRIS; and**
- **Further articles and interviews have been generated related to the NAHSSS discussed on ABC Country Hour, ABC Orange, Kalgoorlie Miner, Sunday Telegraph and Ballina Shire Advocate.**

S•A•R•R•A•H

Services for Australian
Rural and Remote Allied Health

Office Address:
40 Thesiger Ct
Deakin, ACT 2600

Mailing Address:
Services for Australian Rural and Remote Allied Health
PO Box 74, Deakin West ACT 2600

ABN: 92 088 913 517

Phone: +61 2 6285 4960
Toll-free: 1800 338 061
Fax: +61 2 6162 4094
Email: sarrah@sarrah.org.au

www.sarrah.org.au