"General practice has allowed me to be the kind of doctor that I want to be where I can pursue and develop my special interests. For me, this meant heading to Antarctica for Advanced Specialist Training in remote health. This experience allowed me to combine the challenge of learning medicine in an extreme environment with travelling to one of the most remarkable places on earth."

Dr Kate Kloza
OUR VISION AND VALUES

VISION
Better health for rural and remote people through access to skilled rural doctors.

MISSION/PURPOSE
To provide leadership, training and support for rural generalist doctors that promote effective systems of care for their communities.

VALUES
We are professionals
We work with expertise, dedication and care. We take pride in our achievements and always work in a manner that is respectful and friendly.

We are innovators
We actively encourage and look for better ways to achieve results. We are pragmatic, adaptable, flexible and forward thinking.

We are advocates
We are committed to making a positive difference for our members, colleagues and communities. We work together and with others to improve policy, systems and outcomes wherever we can.

We are one
We are a team of strong and diverse individuals unified by a common purpose. We inspire and support each other. We are one.

“Working as a rural doctor means so much more than providing primary care in clinic. As a member of the Rural Emergency Responder Network in South Australia, I may be called to pre-hospital incidents to support local volunteer ambulance, road crash rescue, and emergency services.”

Dr Tim Leeuwenburg (left), rural doctor working as a Pre-hospital Responder
Welcome to our celebration. It is now 20 years since the establishment of the Australian College of Rural and Remote Medicine, and I am pleased to report we continue to move from strength to strength.
With over 1,600 Fellows and membership approaching 5,000, the College now has a substantial presence in training, education, and standard setting for health care in Australia and internationally. What an achievement! Never underestimate what can be achieved when rural doctors come together with a common purpose.

As I write this, candidates for the role of Rural Health Commissioner are being interviewed. The College looks forward to working closely with the commissioner to improve the health outcomes of rural and remote communities. The commissioner’s first task is to establish a national rural generalist program. The FACRRM training pathway has demonstrated its effectiveness in producing doctors appropriately skilled, confident and competent to work in rural and remote Australia and we look forward to sharing our learnings with the commissioner.

Analysis of the MABEL data set shows that FACRRMs are 3.4 times more likely to be working in rural and remote areas than GPs without this qualification. In essence, the FACRRM training program provides better doctors for rural and remote Australia, and those doctors stay on.

This April in Cairns, the College co-hosted the World Summit on Rural Generalist Medicine with the Canadian Society of Rural Physicians. The Summit developed an international action framework for Rural Generalism. This was followed by the inspirational 14th World Rural Health Conference in Cairns which the College hosted for WONCA (World Organisation of National Colleges and Academies of General Practice/Family Medicine). Nearly 1,000 people from 38 countries attended and created a huge level of excitement about the future of rural health care. International guests were encouraged by the policy and conceptual lead set by Australia and particularly by ACRRM. These highly successful events showcased the capacity and excellence of our College staff and leadership.

This year, the College has developed and implemented policies and procedures for college-led selection of trainees. ACRRM is now able to directly select GP trainees, for the government-funded AGPT Program, using criteria that identifies their commitment to and capability to become a rural or remote practitioner. We see this as another stage in creating the pipeline to provide a strong workforce of competent and confident rural generalist doctors for the bush. This has been an enormous body of work. I would like to thank stakeholders, Regional Training Organisations and members of staff for their dedication to seeing it through.

I would like to finish by thanking Fellows, members and staff of this marvellous College that I have the privilege to lead. I thank you for your passion, your commitment, and your hard work. I thank you on behalf of your patients, your communities and your loved ones. You are making a difference today and you will make a difference tomorrow and the day after that, and the day after that. And Australia and the world will be a better place because of you. Thank you.

Ruth Stewart
President
CEO’S REPORT

It’s been a year of training and policy growth for the College, with key projects increasing recognition of rural generalist medicine.

It’s a cathartic thing to sit down to compose your 20th CEO’s annual report. The first was written in a two-room suburban office, this one with the support of over 50 staff against the background of an accredited training and professional development program and a membership base approaching 5,000. While the scale of operations has transformed, the challenges to provide more and better doctors to our rural and remote communities remain. For the organisation, the imperative to stay ahead of the game remains – to not just get bigger, but to continuously innovate, improve and adapt to meet members’ needs within an ever-changing sector.

Recognition of the College and Rural Generalist Medicine

The College has had another huge year in promoting Rural Generalism on the national and international stage hosting three major conferences including the World Summit for Rural Generalist Medicine. The Summit included the launch of the Rural Generalist Program Japan supported by the College and based on the ACRRM approach. The College has continued to progress the national agenda with ongoing talks with the Minister and particularly through membership on the state rural generalist jurisdictional forum. With the appointment of a Rural Health Commissioner to oversee development of the national framework for a Rural Generalist pathway imminent, the College looks forward to taking a leading role in this important work.
National Policy and Advocacy

The national policy environment has seen a welcome change in focus from increasing workforce numbers, to addressing the persistent workforce maldistribution. The College continues to advocate that this means recruiting and retaining a medical workforce that is of the highest quality and able to meet community needs wherever those communities may be.

The College has been active in promoting these principles in the Health Care Homes trials and also in the proposed changes to the Practice Incentives Program which would see the introduction of a broader quality incentive payment.

The Medical Board of Australia released a discussion paper on Revalidation towards the end of 2016. The College has engaged extensively in consultations both with the Board and with its members to ensure developments are fit-for-purpose for our members and their quality practice and initially delayed the release of the Professional Development Program (PDP) Handbook for the 2017-2019 triennium pending discussions with the Board. While we know that the College PDP is strong and robust, it was reassuring to receive advice that it is well placed to meet any further strengthened PDP requirements.

The College is represented on a number of important national committees. These include the National Medical Training Advisory Network, which provides policy advice on medical workforce planning and the development of training plans, the GP Training Advisory Committee and the Practice Incentives Program Advisory Group. We continue to work closely with the Australian Digital Health Agency and through reference committees for initiatives such as the MBS Review and Health Care Homes.

Organisational Expansion and Restructure

During the year we have continued to reinforce the alignment between the College purpose, governance and business structure at all levels of College operations.

There has been increased investment in new roles and business resources to increase strategic and operational capacity. In particular, a major commitment to Education Services has seen a 20 per cent FTE increase in staff overall including creation of an Education Services General Manager and two additional manager level positions.

The activities of the newly-formed Quality and Safety in Practice Council reflect the increasing evidence-based focus on practice quality and safety. The Council oversees the work of the Research, Digital Health and Professional Development Committees and a number of Rural Generalist Working Groups have been formed under its auspices. These groups will provide more specialised input into areas such as obstetrics, anaesthetics, surgery and mental health.

The College has formally endorsed a new Stakeholder Engagement Strategy. As part of the implementation process and consistent with the College Vision and Purpose, we are working to secure input from community and consumer representatives in many levels of College governance.

Registrar Training and Support

The College has now taken carriage of selecting its registrars on the AGPT program. This is a positive step in terms of our capacity to select and better engage with our registrars. It has been a major undertaking to complete all the necessary policy and administrative work associated with this new area of responsibility, and College staff and clinical advisors have responded admirably to the challenge.

A new College mentoring and leadership program was launched in October 2016, with the initial focus being to link interested Registrars with Fellows who can provide support outside the more formal education and assessment processes. This has been very well received and already some 100 members have registered for the program.

Membership and Member Services

Member numbers are steadily rising, with overall growth of over 15 per cent over the past two years and strong retention rates. Importantly, member satisfaction is also improving steadily and on track to reach strategic targets. As outlined in other sections of this report, participation in the College Professional Development Program and our various education courses has also increased by 18 per cent since the last triennium.

The College is expanding its offerings in terms of online forums and communities of practice in response to a rapid increase in member interest and building on well-established and popular programs such as the ruralEM Forum, Ophthal-Assist and Tele-Derm.

The College has introduced a Rural Experienced Entry to Fellowship (REEF) program in response to demand and need for a streamlined opportunity for experienced and eligible rural doctors to become Fellows of the College. The interest in this program has been gratifying and reflects the reputation of FACRRM as a qualification, indicating a full scope of practice to meet community needs.

These and other College education programs will be enhanced by new Learning Management System software. A tender process has been completed and a new system will be introduced in the coming year.

In concluding I’d like to take this opportunity to honour our members, new and old, whose unwavering commitment to the ACRRM vision has brought us thus far. I sincerely hope that in supporting you, we can continue to be equal to your passion and your strength of purpose.

Marita Cowie
CEO
CENSOR-IN-CHIEF REPORT

It has been a year of positive change for the College in the areas of assessment and training, and I’m pleased to report on our sustained growth in our twentieth year of operation.
Achievements
The College is pleased to take on roles previously managed by the Department of Health, the most significant being the selection of registrars for training on the AGPT pathway.

We are now also able to offer grants to encourage rural training research by training organisations and rural research by registrars. The College will now hear Appeals by ACRRM registrars against decisions made by Reginal Training Organisations and approve funding for remediation for registrars who require additional support.

Summative Assessment Change
MiniCEX was previously included as a summative assessment in our initial suite of assessments. At that time, the College supported this approach as the miniCEX is conducted in the candidate's normal working environment and centres on the learner’s clinical skills. However, two significant issues arose with miniCEX: concern about the reliability of this assessment as it is conducted by only one examiner, plus availability of examiners who were able to take time out of consulting to travel significant distances to undertake these assessments. Therefore, in 2016, the summative miniCEX was phased out and replaced with Case Based Discussion (CBD) assessment.

Flexible approaches for Primary Rural and Remote Training
The College requires registrars to have experience in rural and remote practice, community primary care, hospital inpatient care and emergency care. In 2017, a suite of options for meeting these requirements were articulated that reflects a more flexible approach to Primary Rural and Remote Training requirements.

Recognition of Prior Learning Policy
In response to feedback from training organisation we refined our Recognition of Prior Learning (RPL) policy and its implementation. The maximum amount of RPL was reduced to two years for AGPT and RVTS pathways and three years for the Independent Pathway. Registrars now submit a training plan along with applications for RPL to ensure training is well planned.

Accredited Training Organisations
The College reviewed the Standards for Training Organisations to reflect changes in training policies and to ensure alignment with AMC standards for assessing specialist medical education and training. The standards were implemented in 2016. Six of the ten Training Organisations have undergone an accreditation review against these standards during the year.

All of these issues demonstrate The College's continuing commitment to a robust and flexible approach to policy and application of our standards for training and assessment. We look forward to modification and improvement of standards and policies as the College continues to grow.

David Campbell
Censor-in-Chief
POLICY HIGHLIGHTS

The College promotes the interests of its members and their rural, remote and Aboriginal and Torres Strait Islander communities through a rigorous program of advocacy and involvement with national policy development forums.

The College is represented on over 150 national and jurisdictional forums. Over and above these commitments, the year has involved a full program of submissions and deputations in response to emerging developments in the sector.

**Major Submissions and Consultation**

**National Rural Generalist Pathway**
Talks continued with the Minister, health departments and members on the jurisdictional Rural Generalist Forum to progress the Pathway. Hosted the third World Summit on Rural Generalist Medicine.

**Rural Generalist Program Japan**
Supported by the College and drawing on the ACRRM approach. This was launched at World Summit on Rural Generalist Medicine in April.

**Reconciliation Action Plan**
Developed in collaboration with Reconciliation Australia.

**Aboriginal and Torres Strait Islander Members’ Group**
Established to provide a support network for our members and to provide a reference group for the College on issues of relevance to Aboriginal and Torres Strait Islander peoples.

**External Engagement Strategy**
The College has developed and operationalised its strategic plan to strengthen its work in engaging with external stakeholders including community and consumers, state jurisdictions, Primary Health Networks, and medical and rural organisations.

**Options for Revalidation in Australia**
Submission and discussion with the Medical Board of Australia and other stakeholders.

**Redesigning the Practice Incentive Program**
Submission and ongoing consultation.

**Fifth National Mental Health Plan**
Including participation in stakeholder and writing workshops.

**Draft National Maternity Services Framework**
Followed by further engagement and a major stakeholder workshop.

**Rural Workforce Training and Distribution**
Submissions to the Department of Health regarding rural workforce outcomes and the Review of the Aboriginal and Torres Strait Islander Salary Support Program.

**Review of Rural Procedural Support Programs**
Consultation with the Department of Health and evaluation consultants as part of the review of the Rural Procedural Grants Program and the General Practitioner Procedural Training Support Program.
As a young boy, Dr Marjad Page knew he wanted to help his family. He saw his family and friends go in and out of hospital, so he decided that when he grew up his role would be to help them and his community.

Encouraged to be different, to make a difference
On his first day of medical school, Dr Page discovered how to help his family: to become a rural general practitioner and return to his home town of Mount Isa.

As a young Indigenous man, there were many hurdles for Dr Page to overcome throughout his training, but with his family as a driving force and support network, he moved away to study. All of his work and sacrifice paid off, and this year, Dr Page received Fellowship of the College.

Connection to country a key to success
One of the most significant sacrifices for Dr Page was moving away from his home, his community, his family, and his mob. Losing this connection made being away that much more difficult, whilst also fueling the desire that the young student had to return to Mount Isa after his studies. While this was mostly an internal struggle and not necessarily the view of those around him, this made him work harder to be the best doctor he could be, and has shaped him to be the rural generalist he is today.

Dr Page believes it is fundamental for health professionals to return to live and work in their home town.

“No-one can know a community better than a person born and bred in that community. It takes a lifetime to understand the systems and protocols of the culture, the land and the people. This knowledge is priceless,” he said.

Embracing Indigenous heritage
Growing up with a strong link to his Indigenous heritage, it was necessary for Dr Page to adjust quickly to the western curriculum once commencing his studies. This required hard work, extra effort, and serious dedication to his studies. As a junior doctor, he still felt the need to prove to his colleagues and community that he belonged.

Dr Page has achieved Fellowship and is now a Mentor within the College’s Mentor and Leadership Program that helps pave the way for registrars working towards their own fellowship of the College.

Dr Page believes it is crucial to provide specialised education within communities and to surrounding communities, to overcome the barriers for young people living in rural and remote Australia in becoming rural generalists. When asked what advice he would give to the young people of Mount Isa who wanted to become a GP, he responded with:

“The biggest thing is to have a dream. Dreams are what make us wake up at 6am in the morning and work. They motivate us to stay up a bit later at night. They push us a little bit more when we didn’t think we had any more to give.”
RURAL DOCTOR SUPPORT AND PROFESSIONAL DEVELOPMENT

During the 2016–2017 financial year the growth in new Fellows has been steady, and there has been a significant increase in course accreditations and new PDP enrolments.

**Procedural Grants Program**

The Rural Procedural Grants Program (RPGP) aims to enhance retention of procedural practitioners in rural and remote areas by maintaining the skill levels of rural and remote procedural and emergency medicine general practitioners through improved access to relevant educational activities.

Support is provided through a grant payment which contributes to meeting the professional and practice costs incurred by these doctors in attending educational activities.

The RPGP is jointly administered by ACRRM and the Royal Australian College of General Practitioners (RACGP) through the Procedural Medicine Collaboration, chaired by Associate Professor Bruce Chater, a past President of the College.

Since its inception in 2004, the number of registrants registered with the College to access both the procedural and emergency medicine components of the program has almost trebled to the current total of over 1,200 registrants. There has also been a steady increase in the total number of training activities accessed annually since the inception of the program.

The College also administers the anaesthetics component of the General Practitioner Procedural Training Support Program (GPPTSP). The program aims to help overcome workforce shortages and increase the availability of anaesthetics services in rural and remote areas by supporting rural and remote GPs to complete the procedural training program in anaesthetics.

Round 7 of the annual funding rounds occurred during the 2016–17 financial year. There were a total of 50 applications for 15 available scholarships. One of these applicants has now fully completed procedural training in anaesthetics and the remainder are in various stages of completion.

**Professional Development Program**

The College Professional Development Program articulates the College’s professional development standards and reflects its requirement of Fellows and members to retain skills appropriate for safe, independent general practice, especially in rural and remote communities. PDP participants are able to undertake all of their continuing professional development and quality assurance activities for recognition as a specialist in general practice, recognition as a general practitioner with Medicare Australia, maintenance of professional standards, and for other reporting purposes.

The College Professional Development Committee, chaired by Dr Ian Kamerman, oversees the program and a small, efficient and dedicated team of College staff are kept busy in liaising with course providers; coordinating the accreditation of courses; maintaining records and supporting the Fellows and members who are enrolled in the PDP.

Over 2,610 course accreditations

Over 90 new fellows

An unprecedented 461 new PDP enrolments

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The 2014–2016 triennium finished on 31 December 2016 and the College successfully reported on the compliance status of Fellows and members for that period, for maintenance of vocational recognition and procedural qualifications.

PDP participants have access to a purpose-built online platform which includes a personal dashboard on which they can register for courses and receive alerts about upcoming events. They can also manage and monitor their PDP status with their individual PD portfolio and produce a record of their activities on demand.
Domestic Violence Education Package for Rural Doctors

The College has been commissioned by the Commonwealth Department of Health to develop a unique domestic violence prevention education package.

The package includes an education module designed specifically for doctors in rural, remote and Aboriginal and Torres Strait Islander communities. It aims to assist them to more effectively respond to patients experiencing domestic violence and to contribute to domestic violence prevention in their communities.

The project team has been led by Dr Jennifer Delima who has over 20 years experience working in the area and currently leads the Central Australian Sexual Assault Service. Dr Delima is supported by a project team with unparalleled, combined experience in working with victims and perpetrators of domestic violence as they present in medical practice across the diversity of our rural, remote and Indigenous Australian communities.

It includes Dr Sarah McEwan, Dr Carmel Nelson, Dr Bill Liley, Dr Molly Shorthouse, Dr Chris Carroll, and Ms Melanie Rarrtijwuy Herdman, acting CEO, Miwatj Health Aboriginal Corporation.

As part of the project, Dr Delima has delivered a series of workshops including at RMA 2016 and at the WONCA World Rural Health Conference. The team will be delivering another workshop to launch the module at RMA 2017 in Melbourne.
20 YEARS OF ADVANCING RURAL GENERALIST MEDICINE

ACRRM incorporated in March 1997 with 600 foundation members

1997

1998
Primary Curriculum launched – includes first complete Aboriginal and Torres Strait Islander health vocational training curriculum

Rural and Remote Area Placement Program launched – first national prevocational rural training program designed and developed by ACRRM

1999

1999–2000
PRESIDENT
Dr John W (Jack) Shepherd

2000

2000–2003
PRESIDENT
Lexia R Bryant

2001

2001
RRMEO formally launched – world’s first online platform devoted to rural doctors’ education

2002

2002
ACRRM PDP recognised for maintaining VR (Vocational Registration)

2006

2006
AST curricula program introduced

2005–2007
PRESIDENT
Dr David Campbell

2003–2005
PRESIDENT
Professor Ian Wronski

1997–1999
PRESIDENT
Dr Alan (Bruce) Chater
Since our inception, ACRRM has strived to establish ourselves as the great disrupters of generalist medicine, both in Australia and internationally.

We pride ourselves on our innovation and agility in introducing world first programs on rural generalism, including the first primary curriculum dedicated to rural generalist practice and the world’s first online medical education platform dedicated to rural practice, RRMEO.

We would like to take this opportunity in our 20th year to thank our members, staff, board and for playing their part in all that we have achieved. Here’s to another 20 years of growth and success.
REGISTRARS AND VOCATIONAL TRAINING

College-led AGPT selection a positive step in finding the right candidates for rural generalist practice.

644 current registrars
213 Fellows contributing to College programs
700 assessments conducted

College-led selection for the Australian General Practice Training (AGPT) Program

This year saw the culmination of some years’ effort to transition the selection process for AGPT to both colleges. The College is now able to select its registrars for AGPT according to its own selection criteria:
1. Demonstrated commitment to a career as a specialist general practitioner working in a rural or remote Australia
2. Demonstrated capacity and motivation to acquire abilities, skills and knowledge in the ACRRM domains of practice
3. Demonstrated connection with rural communities
4. Demonstrated commitment to meeting the needs of rural and remote communities through an extended scope of practice
5. Possession of the personal characteristics associated with a successful career in rural or remote practice.

With a six-month lead time, the College was delighted to find that initial applications exceeded the quota of 150 places which had been allocated by the Department of Health. The selection process has three stages:
1. Department of Health determines candidate eligibility
2. ACRRM requires candidates to submit short answers online to questions which address the selection criteria
3. ACRRM conducts Multiple Mini Interviews (MMIs) in each of the 11 regions in which applicants have indicated they wish to train.

All ACRRM applicants will train on the rural pathway, and education in the Program will continue to be delivered through the Regional Training Organisation network.

This year also saw the transition of other important programs from Department of Health to the College. These programs include: Regional Training Organisation Education Research Grants, Registrar Academic Posts, and management of Appeals and Remediation involving College registrars on the AGPT Program.

Support for registrars

The College has focused on increased support for registrars with a number of initiatives and a focus on practical support:
- Revision of face-to-face workshops for Independent Pathway registrars to include more practical sessions and a broader range of topics
- Revision of the 16 week virtual classroom program each semester for Independent Pathway registrars
- Additional resourcing in Education Services, including the General Manager and a manager for each of the areas of Vocational Training and Assessment
- Increased capacity in study groups for facilitated preparation for assessments for registrars on all pathways. Study group participants are now grouped geographically to facilitate peer to peer interaction and to open informal channels with other registrars in the same region.
Independent Pathway

We are pleased to report that 32 registrars commenced on the Independent Pathway this year. Queensland residents comprise 34 per cent of the cohort with 22 per cent in each of New South Wales and Western Australia. The cohort is represented by males and females equally.

The College intends to build on its profile in the Northern Territory and South Australia where underserviced communities would welcome a stronger workforce of rural doctors with the extended scope of practice in which FACRRM general practitioners excel.

Assessments

The College assessment approach maintains a commitment to a balance of formative assessment for feedback purposes and summative assessment to determine progression. Feedback is provided through two paths:

- Formalised formative assessments; and
- Feedback from summative assessments.

The College conducted over 600 assessments, an increase of 12 per cent over the previous year. The key developments in assessment include:

- Publication of Public Reports at the completion of each StAMPS and MCQ exam
- Introduction of Case Based Discussion (CBD) as a summative assessment
- Enrolling additional examiners into the pool of assessors and conducting training for those examiners.

Thank you to all Fellows who are providing support and contributing to the College’s training and assessment programs. Without your assistance, these programs would not be available.

Advanced skills for better doctors

The trends in advanced specialised training have remained fairly consistent over the years. The procedural disciplines are the most frequently chosen with Emergency Medicine the most popular followed by Anaesthetics, O&G and then Surgery. Of the non procedural disciplines Adult Internal Medicine draws the largest numbers followed by Population Health, then Aboriginal and Torres Strait Islander Health, and Mental Health, Remote Medicine and Paediatrics in similar numbers.

International Medical Graduate Programs

The College’s commitment to bringing better doctors to rural and remote communities has led to it becoming a national leader in the assessment of qualifications, experience and competencies of International Medical Graduates (IMGs) and a key vocational training provider for IMGs.

The College is Australia’s most experienced provider of these vital assessments and is accredited to provide these in every state and territory. Since commencing in 2009, the College has completed over 2,000 Pre-employment Structured Clinical Interviews, or PESCI. In the past year, we completed 687 individual PESCI interviews and 8 Specialist Pathway interviews.

IMGs are significant and important contributors to our rural and remote medical workforce. The College has embraced its responsibilities to ensure that high quality doctors are assessed as competent to practise in Australia, and to encourage, train and support these doctors to bring out their best as rural and remote practitioners.

The College’s various IMG programs are specifically designed to offer IMGs additional opportunities to demonstrate their capabilities and qualify for registration and/or vocational recognition in Australia.

Over the reporting period, all Fellowship and registration pathways provided by the College have upheld their Australian Medical Council (AMC) accreditation to conduct assessment.

The College continues to craft new pathways to registration and Fellowship to better meet the diversity of candidate experience and educational needs.
NEW FELLOWS

Congratulations to this year’s new Fellows.

Dr Peter Abdelmalek
Dr Adefolarin Adebajor
Dr John Adie
Dr Armi Aganan
Dr Akua Agyeman
Dr Antonio Arcibal
Dr Philipp Argy
Dr Muhammad Arshed
Dr Erlank Barnard
Dr Megan Belot
Dr Hollie Berghofer
Dr Dean Boyatzis
Dr Darren Briggs
Dr Muhammed Bukhari
Dr Paul Butel
Dr Nicholas Cairns
Dr Heather Carev
Dr Charles Cassar
Dr Kathleen Chang
Dr Kerryn Chatham
Dr Fung Cheng
Dr Marlow Coates
Dr Carmel Cockburn
Dr Anne Collins
Dr Claudia Collins
Dr Katherine Comparti
Dr Robyn Cooke
Dr Renee Cremen
Dr Brooke Davies
Dr Nathan Dawe
Dr Jaidee Dennis
Dr Rebecca Devereaux
Dr Michael Donnelly
Dr Maya Eamus
Dr Craig Fairley
Dr Sarah Farlow
Dr Liam Flynn
Dr Rodney Gangell
Dr Ankush Goyal
Dr Shyam Gurudoss
Dr Gregory Hammond
Dr Emily Harrison
Dr Naomi Houston
Dr Tristan Howie

Dr Bob Irungu
Dr Daniel Isacson
Dr Greg Ivanoff
Dr Kumaravel Kaliyaperumal
Dr Vimbai Kapuya
Dr Katherine Kloza
Dr Sarah Koffmann
Dr Praneel Kumar
Dr Jashnil Kumar
Dr Hosam Mahmoud
Dr Andre Mareyo
Dr Bradley Martin
Dr Andrew Mason
Dr Garry Matthews
Dr Sally McKenzie
Dr Anna McKinlay
Dr Bin Mo
Dr Boris Molodov
Dr Emily Moody
Dr Matthew Moore
Dr Keith Nallaratnam
Dr Andrew Olesnicky
Dr Trevor Palaker
Dr James Charles Phillips
Dr Sivagnanam Rajeev
Dr Alan Richardson
Dr John Ridley
Dr Christine Ross
Dr Sophie Rymill
Dr Jessica Sartini
Dr David Scott
Dr Smriti Shah
Dr Warren Simpson
Dr Patricia Slegers
Dr Clive Strauss
Dr Brian Treanor
Dr Catherine Vogler
Dr Shahid Waheed
Dr David Warhurst
Dr Annette Waterston
Dr Amanda Wisely
Dr Justin Withnall
Dr Clare Wright

For the first time since 1985, Falls Creek Medical Centre has the extended Zagorski family, many of them doctors and GPs, working together in the community.
PROFILE OF A NEW FELLOW: DR JAMIE PHILLIPS

Transferring to the Australia Army from UK Armed Forces put Dr Jamie Phillips on the path to ACRRM Fellowship.

After 16 years working in the UK Armed Forces as a Navy Commando Medical Officer, Dr Jamie Phillips was offered the opportunity by the Australian Defence Force to emigrate with his family and join the Australian Army.

As an experienced Military General Practitioner with over a decade of frontline operational experience in remote medicine, pre-hospital emergency and retrieval medicine it didn’t take much to convince Dr Phillips that a move to Australia was the correct choice.

“The timing was perfect. I had reached a point in my career where I was being drawn away from what I love, providing high quality healthcare on the battlefield, so I grasped the opportunity to follow a new adventure in Australia with both hands. After retiring from the UK Armed Forces I spent a single morning as a civilian in London before being sworn into the ADF at Australia House” he said.

“I came across as an international medical graduate on the Specialist Pathway and after spending a fixed period in supervised practice in general practice and emergency medicine in Australia, I was able to achieve Fellowship of ACRRM in May 2017.

“Prior to emigrating and joining ACRRM I had never considered myself to be a rural generalist. In the UK I was a General Practitioner with a special interest in remote medicine and pre hospital emergency medicine, but there was no single professional College that encompassed the broad scope of rural and remote medicine. In reality, I've always been a rural generalist – it just took coming to Australia for me to find ACRRM and realise that.”

Dr Phillips is currently employed as Senior Medical Officer for the 2nd General Health Battalion where he fulfils a number of roles depending on whether he is working in the deployed or garrison environment.

When in barracks, Dr Phillips spends two days per week providing community practice care to Defence personnel and a further two days per week working in emergency medicine in the civilian healthcare system. He reserves one day per week for military training and to provide mentoring for the junior doctors, nurses and medics under his supervision.

“When asked about the differences between working with the Army and working in a rural community, Dr Phillips said that surprisingly, there aren’t that many.

“When I’m working for the Defence Force, I’m providing care that is almost identical to that I would provide in a rural clinic or community hospital,” he said.

“My patients typically aren’t as old or as young as the patients I see when I work in the community, so I don’t often deal with age-related illness, but I still see a huge range of scheduled and unscheduled primary healthcare problems in my daily practice”.

“I’m doing the same work as any rural and remote GP. Sometimes the situation dictates that I work alone, sometimes I am able to work as part of team of allied health professionals; the ability to adapt to changing situations is key to my role. I particularly enjoy working with and learning from the next generation of doctors, my interns and registrars, who I try to introduce to the challenging world of rural and remote medicine.”
“The real difference is during deployment. When we’re deployed we are working in a Level 3 trauma facility that aims to provide an Australian standard of healthcare no matter where we are working. We are able to provide rapid access to specialist primary healthcare, emergency medicine, damage control surgery, intensive care, dentistry, physiotherapy, psychology and even veterinary medicine for defence force members.”

For Dr Phillips, that’s the beauty of rural and remote medicine; at its core, it’s about servicing the needs of the patient, wherever and whatever they may be.

“Being a rural generalist is the best way to use my skills and provide care to more individuals. And achieving Fellowship of ACRRM helped me get there.”
ACRRM FLAGSHIP COURSES

In 2016–2017, the College directly delivered training in tailor-made priority skills courses for around 620 Fellows. Members have benefited from access to the 42 face-to-face course presentations.

Rural Emergency Skills Training (REST)
The College developed the Rural Emergency Skills Training course to define emergency skills that are foundational to safe, quality rural practice for registrars, IMGs and experienced doctors. The two-day course was successfully delivered on 24 occasions this financial year including eight courses direct to organisations. Across all courses, over 450 doctors in Victoria, New South Wales, Western Australia, Queensland and the A.C.T. undertook the REST course including for the first time in Alice Springs, Adelaide and Dubbo.

The expansion of REST has allowed growth in attendance and the opportunity to present in every state and territory. This provides members with the opportunity to attend the course closer to home or travel if desired. Our ongoing relationship with RTOs has seen us become the “go to” College for rural emergency skills for registrars.

Advanced Life Support (ALS)
In 2016-2017, we completed our third triennium of the mandatory Professional Development Program (PDP) of ALS requirement. Through our tailor-made program of Fellows training Fellows, we saw strong connections being fostered amongst our membership.

The one-day course was successfully presented on 12 occasions to 235 doctors in Melbourne, Cairns, Brisbane, Townsville and Mackay. Four of these courses were presented for Primary Health Networks directly and this continues to be an area of focussed growth.

Rural Emergency Obstetrics Training (REOT)
The one-day Rural Emergency Obstetrics Training course is designed for non-obstetricians working in emergency departments or in primary health care settings and aims to provide a practical foundation for management of emergency labour and birth in these clinical settings. Five REOT courses were delivered to 90 participants in Cairns, Melbourne and Canberra over the year and in Perth for the first time.

Introduction to Ultrasound Use in Rural Emergency Medicine
The one-day Ultrasound Use in Emergency Medicine course continues to be supported by and presented in conjunction with SonoSite FujiFilm, who provide the portable ultrasound machinery and expert clinical specialist sonographer input into these popular “hands-on” workshops. Five workshops were delivered in Canberra and Brisbane along with Adelaide and Cairns for the first time. There were 93 participants and 30 medical student models involved.

Mental Health Skills Training (MHST)
This national priority area is of critical importance for rural practitioners in the virtual absence of a rurally-based psychiatry workforce. The College course was developed by the College for members working in primary health care settings with minimal mental health skills training. It is accredited by the General Practice Mental Health Standards Collaboration (GPMHSC) and includes a focus on developing skills in assessment, planning and review. Completion allows members access to Medicare items 2715 and 2717.

The College has continued to encourage completion of this course to members and during the year over 150 Fellows, members and registrars attended either through face-to-face or virtual classroom options.
## Courses by ACRRM

<table>
<thead>
<tr>
<th>Course</th>
<th>Number of workshop programs</th>
<th>Number of participating doctors</th>
<th>Locations for delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Emergency Skills Training</td>
<td>24</td>
<td>450 doctors</td>
<td>ACT, NSW, QLD, WA, VIC, SA and NT</td>
</tr>
<tr>
<td>Advanced Life Support</td>
<td>12</td>
<td>235 doctors</td>
<td>Brisbane, Cairns, Mackay, Townsville, Lismore, Melbourne</td>
</tr>
<tr>
<td>Rural Emergency Obstetrics Training</td>
<td>5</td>
<td>90 doctors</td>
<td>Perth, Cairns, Brisbane, Melbourne</td>
</tr>
<tr>
<td>Introduction to Ultrasound use in Rural Medicine</td>
<td>5</td>
<td>93 doctors</td>
<td>Perth, Cairns, Brisbane, Melbourne</td>
</tr>
<tr>
<td>Mental Health Skills Training</td>
<td>7</td>
<td>150 doctors</td>
<td>Online via virtual classrooms and face to face in Longreach and Sydney</td>
</tr>
</tbody>
</table>
JUNIOR DOCTORS AND MEDICAL STUDENTS

This year saw 99 future generalists engage with the College at Rural Medicine Australia, and 125 students make a global impact at Rural WONCA.

Future Generalists’ Committee
Engaging with students, interns and residents interested in general practice ensures the continued success of the College, and this year led to the establishment of the Future Generalist Committee, the first meeting of which was held in August 2016.

The Committee was established to give a voice to student, intern, and resident membership of the College. The purpose of the Future Generalists’ Committee is to ensure that these members are reflected in internal decision-making and activities, and to advance the mission and values of the College in external forums relevant to medical education, rural health, and careers in rural medicine.

The Committee is represented by 13 students, residents and interns from across Australia.

Partnering with Rural Health Clubs and Rural Clinical Schools
The College continues to build strong working relationships with Rural Clinical Schools (RCSs) and Rural Student Clubs to create a seamless rural training pathway from medical school through to vocational training.

Throughout the year, we have worked collaboratively with schools and clubs to deliver John Flynn Placement Program information sessions, host and advertise student engagement and networking events, and provide speakers and information at relevant career and university events.

ACRRM national curriculum, standards and resources for Junior Doctors
The College has been developing a national curriculum and standards framework to guide and support quality prevocational training in rural and remote areas. The College is committed to building a structured Rural Generalist training pathway and the framework fills an important gap in this passage.

The national framework defines appropriate coursework and training standards for intern and junior doctor training as well as identifying the learning and experience in the early medical graduate years to streamline progress to College Fellowship training.

This body of work comes in conjunction with the education package the College has been commissioned to develop for Queensland Health to define and certify a Rural Generalist Medicine Term to the College’s national standards. This will be available to Queensland Health doctors prior to commencement of vocational training. To support the clinical experience gained through the term, the College has developed the Rural Generalist Foundation Skills suite of modules, including:

- An introduction to the rural and remote context
- Aboriginal and Torres Strait Islander health
- Population Health
- Digital health
- Clinical resilience

The framework and education package will be launched at RMA 2017 in Melbourne.
INTERVIEW: DR KATH MAHER

“I have caught the bug! I would love to go back to Antarctica and work in that environment. I felt like I got a tiny taste of the Antarctic experience and now I want more.”

What do you believe to have gained most from doing the John Flynn Placement Program through The Australian College of Rural and Remote Medicine?

I have gained such a great insight into how the Polar Medical Unit in Antarctica work, an experience that I think I can say few doctors get before they embark on an expedition. I have made some great connections, friends, and met incredible doctors who have done some truly inspiring things.

What was it like undertaking your placement in Antarctica?

After learning about Antarctica in primary school, at the age of seven, I decided that it was somewhere that I would go. Having had this goal for so long I had a lot of preconceived ideas and expectations about what I would experience in Antarctica, which were certainly met and exceeded. A large portion of my expedition to Antarctica was spent on board the Aurora Australia, the Australian Antarctic Divisions icebreaker. I did a round trip on the Aurora to Davies station for their resupply.

Do you have any advice for students who might be interested in doing a similar placement?

My placement was a very special and rare opportunity, but there are lots of special opportunities out there for medical students. Some of these opportunities are only available as a medical student, so go for them! Think about what the assessors are wanting in an applicant but also be honest and genuine. If you miss out on an opportunity, remember there are others out there and go looking for them.

What were some of the difficulties in providing health services in Antarctica?

It is hard to put into words how beautiful, vast, and alien Antarctica is. Antarctica is one of the last truly remote areas on this earth. This means preparation is everything. During winter, most of Antarctica becomes inaccessible to ships or planes. In recent years the boundaries have been pushed to retrieve patients with life threatening conditions that had previously been deemed too dangerous. The extraction of critically ill patients often relies on the goodwill of international stations to facilitate patient retrieval.

How do you think GPs can further help the health services in Antarctica?

There are a number of ways GPs can be involved in the Australian Antarctic program, from completing initial health checks, to working at the Antarctic division, to being an expedition doctor. One important way GPs can help the health of those who have travelled to Antarctica is to check in with them once they return. An expedition to Antarctica is an incredible experience but it can be taxing on people’s mental health, both while they are away and then when they reintegrate into their lives back home.
ONLINE SERVICES

A successful year of growth for online education, clinical guidelines and the learning management system.

**ONLINE LEARNING**

During the year the College members (and RRMEO subscribers) have enjoyed access to over 100 online modules. This translates to over 10,000 enrolments in RRMEO modules.

The publishing team were kept busy with the eHealth enabled management of chronic conditions and PESCI Applicant Preparation production projects. In addition, 26 new Tele-Derm education cases, regular rural EM forums and many other sundry projects were completed.

**Youth friendly consultation skills**

In partnership with the Maternity, Child, Youth and Paediatrics Unit in Ministry of Health (NSW Government), the College has developed an online module around Youth Friendly Consultation Skills.

The online module aims to assist participants to:
- assess youth health problems in line with the adolescent’s stage of development
- conduct a youth friendly consultation, including explaining confidentiality, negotiating to see a young person alone, and using youth friendly communication skills
- perform a health risk assessment using the HEEADSSS psychosocial screening tool.

The module is presented by Clinical Professor David Bennett, an adolescent health physician with a major interest in the development of integrated, creative health services for young people and their families.

**Clinical Guidelines for Mobile Devices**

The College released a comprehensive update to the guidelines resource in January 2017.

The main focus was to produce new and amended guidelines to align with the College’s Primary Curriculum and the Advanced Specialised Training curricula. The update included 60 new guidelines and amended over 30 others. Two new disciplines were added: Optimal Cancer Care Pathways Quick Reference Guides and Patient Blood Management Quick Reference Guides.

**Learning Management System**

The College has completed the definition of requirements, engagement, and selection processes for the planned replacement of the current Learning Management System RRMEO. The new platform will deliver significant improvements to the learning experience, increase the options for engagement and decrease the publishing turn around time.

**RuralEM forum**

The ruralEM forum has maintained its momentum with 16 new cases being discussed in the forum. Over 600 doctors are now engaged in the forum and participate in active discussions around each of the cases presented.

**VIRTUAL CLASSROOMS/WEBINARS**

The College has supported over 300 live virtual classroom sessions this year. These have included large scale sessions to support the eHealth enabled management of chronic conditions project, Tele-Derm sessions, Zostavax and many other education sessions, study groups and meetings.

**Collaborate Ultra integration**

The College also migrated to the latest virtual classroom/webinar platform during the year. The new Collaborate Ultra platform allows users to access virtual classrooms direct from their browser. Sessions can also be accessed via a tablet or smartphone app. This has greatly decreased participant technical issues with accessing live sessions with many of our users now participating using their mobile devices.
Digital Health continues to be a priority for the College, with plans for new services extending into the next financial year.

Digital Health Committee
In 2016, the College established a new Digital Health Committee reporting to the Quality and Safety in Practice Council. Chaired by Associate Professor Chris Pearce, the purpose of the Digital Health committee is to oversee the development and declaration of College policy, positions, standards, models, and education in order to facilitate beneficial use of digital health in rural generalist practice.

New eHealth Enabled Care Education Module
In 2016/2017, the technological environment presented an ideal opportunity for exploring an integrated educational approach to the provision of eHealth services in rural and remote communities. This lead to the creation of the eHealth enabled management of chronic conditions module. This education package supports members to enhance practice through eHealth.

Funded by the Australian Digital Health Agency, the module was made available to Australian general practice staff in October 2016.

Rural Health Outreach Fund
In early 2017, the College was awarded an extension to the Rural Health Outreach Fund (RHOF) from the Australian Government. For the next three years, we will now be able to continue providing the Tele-Derm and Ophthal-Assist services to all Australian rural doctors.

The ACRRM Telehealth Advisory Committee, a nationally represented group of over 40 stakeholders supports the RHOF. This collaborative committee shares information and ideas that support the uptake of telehealth into routine clinical practice.

Engagement with digital health programs
Engagement with national and state digital health providers grew this year. The College appointed representatives to the following committees and groups:
- Digital Health Safety and Governance Advisory Committee
- National Medicines Safety program
- Australian Telehealth Integration Program
- Pathology Steering Group
- Diagnostic Imaging Steering Group
- Queensland Health Telehealth Governance Committee

National Digital Health Strategy
The College made a submission to the National Digital Health Strategy outlining the development of a new Digital Health Strategy for Australia. Digital health services extend the scope of practice of Rural Generalists, allowing GPs to provide comprehensive care for patients in their local community.

RANZCR Teleradiology Standards
In March 2017, the College made a submission to the Royal Australian and New Zealand College of Radiologists (RANZCR) Teleradiology Standards draft. Our submission outlined the difference between access to diagnostic imaging and radiological services in rural and remote communities in comparison to urban communities.

Ophthal-Assist Program
The Ophthal-Assist Program was established in 2016. It provides a case-based forum of ophthalmology cases and has over 300 users. This builds on the library of over 1,000 cases assembled for the teledermatology library as part of the Tele-Derm program that has been in operation for twelve years and has over 3,000 users. It receives over 600 cases for advice each year and delivers quarterly webinars which attract over 200 rural doctors per session.
ACRRM HOSTS WORLD SUMMIT ON RURAL GENERALIST MEDICINE

On 28 April 2017, the College hosted the World Summit on Rural Generalist Medicine in Cairns in conjunction with the WONCA World Rural Health Conference.

The Summit attracted over two hundred delegates from 23 countries. It built on the work of the two previous Summits and provided an interactive forum which workshoped key strategies and culminated in presentation of a consensus way forward for Rural Generalist Medicine on a global scale.

Its blueprint was based on the action priorities established at the 2015 Montreal Summit:

- Building recognition of Rural Generalist Medicine
- Strengthening its evidence base
- Toolkits to guide its practical integration into health systems
- Communicating its value to communities and health systems.

Summit highlights included keynote addresses from Mr Jim Campbell, Executive Director, Health Workforce, WHO, and Dr Jillann Farmer, Medical Advisor, United Nations. Dr Farmer reflected on her work including her role leading health services for the UN response to Ebola, noting how valuable staff with FACRRM qualifications could have been to these operations.

Another highlight was the presentation from Dr David Miller who viewed promotion of the challenging skill set and responsibilities of Rural Generalist Medicine as key to recruiting local doctors to work with him throughout rural and remote Papua New Guinea.
HISTORIC MOMENT AT SUMMIT – RURAL GENERALIST PROGRAM JAPAN COMMENCES

The World Summit on Rural Generalist Medicine provided the stage for the historic launch of the Rural Generalist Program Japan.

Dr Manabu Saito, program staff and the first cohort of Rural Generalist registrars were treated to a standing ovation from 200 delighted delegates.

Dr Saito, Director of the Rural Generalist Program Japan (RGPJ), started the first steps toward the RGPJ with the College in May 2015. Since then, the College and its members worked with the tireless Dr Saito toward its establishment.

The program is based on the ACRRM model of training and the College has provided curriculum, standards and resources to assist in program development.

The program’s registrars train on a series of remote Japanese islands which have limited hospital facilities and rely on air transport for access to highly specialised care.

Registrars are also planning for training exchanges in Australia in the near future with some of our senior members.

The College congratulates its good friends at the RGPJ for their historic achievement.
## ACRRM Board and Standing Committees

### 2017 Members

### ACRRM Board

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Role</th>
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<tbody>
<tr>
<td>A/Prof Ruth Stewart</td>
<td>President</td>
</tr>
<tr>
<td>Dr Sally Banfield</td>
<td>Registrar Director</td>
</tr>
<tr>
<td>Dr Sue Harrison</td>
<td>RDAA Representative</td>
</tr>
<tr>
<td>Dr Eve Merfield</td>
<td>Tasmanian Councillor</td>
</tr>
<tr>
<td>Dr Andrew Miller</td>
<td>SA Councillor</td>
</tr>
<tr>
<td>Dr Sally Singleton</td>
<td>WA Councillor</td>
</tr>
<tr>
<td>Dr Bruce Thorpe</td>
<td>VIC Councillor</td>
</tr>
<tr>
<td>Dr Sarah Chalmers</td>
<td>NT Councillor</td>
</tr>
<tr>
<td>Dr Rod Martin</td>
<td>NSW Councillor</td>
</tr>
<tr>
<td>Dr Ewen McPhee</td>
<td>Board member</td>
</tr>
<tr>
<td>A/Prof David Campbell</td>
<td>Director</td>
</tr>
<tr>
<td>Ms Marita Cowie</td>
<td>Chief Executive Officer (ex-officio)</td>
</tr>
<tr>
<td>Prof Lucie Walters</td>
<td>Immediate Past President (ex-officio)</td>
</tr>
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### College Council

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Professor Lucie Walters</td>
<td>Immediate Past President</td>
</tr>
<tr>
<td>A/Prof Ruth Stewart</td>
<td>President</td>
</tr>
<tr>
<td>Dr James Ricciardone</td>
<td>Registrar representative</td>
</tr>
<tr>
<td>Dr Justin Azzopardi</td>
<td>Future Generalists Committee</td>
</tr>
</tbody>
</table>

### Finance and Risk Management Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Role</th>
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</thead>
<tbody>
<tr>
<td>Dr Mike Beckoff</td>
<td>Board Director</td>
</tr>
<tr>
<td>Dr Dan Halliday</td>
<td>Board Director</td>
</tr>
<tr>
<td>Dr Bruce Thorpe</td>
<td>Council member</td>
</tr>
<tr>
<td>Dr Ewen McPhee</td>
<td>Board Director</td>
</tr>
<tr>
<td>Dr James Ricciardone</td>
<td>Council member</td>
</tr>
<tr>
<td>Mr Darryl Perkins</td>
<td>General Manager Corporate Services</td>
</tr>
<tr>
<td>Ms Marita Cowie</td>
<td>Chief Executive Officer</td>
</tr>
</tbody>
</table>

### Education Council

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Role</th>
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</thead>
<tbody>
<tr>
<td>Dr David Rosenthal</td>
<td>Chair</td>
</tr>
<tr>
<td>A/Prof David Campbell</td>
<td>Censor in Chief</td>
</tr>
<tr>
<td>Dr Tom Doolan</td>
<td>Vocational Training Committee Chair</td>
</tr>
<tr>
<td>Prof Tarun Sen Gupta</td>
<td>Assessment Committee Chair</td>
</tr>
<tr>
<td>Prof Dennis Pashen</td>
<td>Post Fellowship Committee Chair</td>
</tr>
<tr>
<td>Dr Michelle Hannan</td>
<td>Registrar Committee Chair</td>
</tr>
<tr>
<td>Ms Anne Gately</td>
<td>General Manager – Education services (ex-officio)</td>
</tr>
</tbody>
</table>
Professional Development Committee
Dr Ian Kamerman
Chair
Dr April Armstrong
Member
Dr Carol Reeve
Member
Dr David Brookman
Member
Dr David Rosenthal
Member
Dr Ralph Chapman
Member
Dr Peter Baker
Member
Dr Suresh Badami
Member
Dr Leonard Brennan
Member
Ms Leisa Ryan
PDP Coordinator (ex-officio)

Assessment Committee
Prof Tarun Sen Gupta
Chair
A/Prof Bruce Chater
Member
Dr Ajay Chipiri
Member
Dr David Rosenthal
Member
Dr Deborah Simmons
Member
Dr Michelle Hannan
Registrar Member
Ms Anne Gately
General Manager – Education Services
(ex-officio)
Ms Karen Connaughton
Assessment Manager (ex-officio)

Registrar Committee
Dr Michelle Hannan
Chair
Dr Sally Banfield
Registrar Director
Dr Rebecca Deveraux
Member
Dr Michael McLaughlin
Member
Dr James Ricciardone
Member
Dr Vimbai Kapuaya
Member
Dr Lyndal Phelps
Member

Ms Lynn Saul
Standards and Accreditation Manager
(ex-officio)

Ms Sandra Johanson
Vocational Training Manager (ex-officio)

Dr Paul Butel
Member
Dr James Chenoweth
Member
Dr Lillian Daniels
Member
Dr Jon Van Bockxmeer
Member
Ms Sandra Johanson
Vocational Training Manager (ex-officio)
Ms Nicole Lind
Training Support Coordinator (ex-officio)

IMG Assessment Committee
Dr Paul de Jong
Chair
Dr Pat Giddings
Member
Prof Tarun Sen Gupta
Assessment Committee Chair
Dr Tom Doolan
VT Committee Chair
Dr Michael Douglas
Member
Dr Peter Finlayson
Member
Prof Dennis Pashen
Member
Dr John Togno
Medical Educator (ex-officio)
Dr Chris Carroll
Medical Educator (ex-officio)
Ms Karen Connaughton
Assessment Manager (ex-officio)
Ms Maxine Crowley
Assessment Coordinator (ex-officio)

Vocational Training Committee
Dr Tom Doolan
Chair
Dr Charles Evill
Member
Dr Rod Martin
Member
Dr James Chenoweth
Member
Dr Vimbai Kapuay
Member
Dr Peter Chilcott
Member
Ms Anne Gately
General Manager – Education Services
(ex-officio)

Ms Sandra Johanson
Vocational Training Manager (ex-officio)
Board of Examiners
A/Prof David Campbell
Censor in Chief and Chair
Prof Tarun Sen Gupta
Assessment Committee Chair
Prof Dennis Pashen
Post Fellowship Committee Chair
Dr Pat Giddings
Member
A/Prof David Rosenthal
Member
Ms Karen Connaughton
Assessment Manager (ex-officio)

Research Committee
A/Prof Lucie Walters
Interim Chair
A/Prof Louise Stone
Member
Jeff Brownscombe
Member
Louise Young
Member
Abbas Hagshenas
Member
Registrar Representative
(appointment pending)
David Campbell
Censor In Chief
Sean Muchmor
General Manager – Quality and Safety
(ex-officio)

Quality and Safety in Practice Committee
Dr Dennis Pashen
Chair
Dr Anthony Lembke
Member
Dr Aniello Iannuzzi
Member
Dr Ian Kamerman
Member
Dr Elisabeth Dodd
Member
Dr Sally Banfield
Member
Dr Neil Beaton
Member
Dr Katie Goot
Member
Dr David Rosenthal
Member
Prof Lucie Walters
Member
Dr Christopher Pearce
Member
Andrew Jamieson
Member
Sean Muchmor
General Manager – Quality and Safety
(ex-officio)

Future Generalists Committee
Dr Justin Azzopardi
Chair
Andreas Hendarto
Member
Ella Worboys
Member
Dr Louise Manning
Member
Dr Joshua Mortimer
Member
Jaffly Chen
Member
Clay Rowe
Member
Dr Stephen Johnston
Member
Dr Geraldo Guimaraes
Member
Dr Leigh McKenzie
Member
Dr Matthew Watson
Member
Dr Lisa Waters
Member
Dr Rebecca Irwin
Member

Digital Health Committee
Dr Christopher Pearce
Chair
Dr Ewen McPhee
Member
Dr Jeff Ayton
Member
Dr Dennis Pashen
Member
Dr Anthony Lembke
Member

Dr John Douyere
Member
Dr Shannon Nott
Member
Sean Muchmor
General Manager – Quality and Safety
(ex-officio)
FINANCIAL STATEMENTS

For the year ended 30 June 2017
A.C.N 078 081 848
DIRECTORS REPORT

The Directors submit the following report for the year ended 30 June 2017 under Sections 298 and 300B of the Corporations Act 2001 and in accordance with a resolution of the Board of Directors.

Directors

The names of the Directors of Australian College of Rural and Remote Medicine Limited in office at any time during the year or since the end of the year:

Dr Sally Banfield
Dr Michael Beckoff
Dr Suzanne Harrison
Associate Professor Lachlan McIver (resigned 31/12/2016)
Professor Lucie Walters
Dr Ewen McPhee
Associate Professor Ruth Stewart
Dr Daniel Halliday (appointed 20/06/2017)

Principal Activities, Objectives and Strategies

The principal strategies of the College during the year were to promote the interests of rural and remote doctors through the delivery of high quality specialist education and training, research, policy and advocacy.

There was no significant change in the nature of the activities during the year. The company’s financial accounts have been prepared in accordance with Australian Accounting Standards.

In order to meet the long term objectives of the College, the company will strive to:

- Be recognised as the leading voice for best practice in rural and remote medicine in Australia
- Proactively support students, members and Fellows with quality education, training and resources
- Engage with and bring value to the full range of medical and rural health professions.

The company’s short term objectives is to focus on growth within existing target markets for the next 12 months and maintain strong member retention.

In order to meet the short term objectives of the College, the company will continue to:

- Encourage a targeted approach to member recruitment
- Place greater emphasis on generating income sources that are independent of government
- Broaden the range of College programs and activities
- Emphasise member and staff satisfaction as a key priority

Key Performance Measures

Management and the Board (through the Finance Audit and Risk Management Committee) monitor ACRRM’s overall performance, from its implementation of the vision statement and strategic plan through to the performance against operating plans and financial budgets.

At this point in time, regular monitoring of revenue targets and delivery of service are a key focus however the Board and management are currently working on a series of quantitative and qualitative key performance indicators for use in future years.

Review and Results of Operations

The profit from ordinary activities for the year ended 30 June 2017 amounted to $611,823 (2016 profit: $574,971).

Winding up Provisions

Every member undertakes to contribute to the assets of the Company if it is wound up while the member is a member or within one year after it ceases to be a member, for payment of the debts and liabilities of the Company contracted before it ceased to be a member, and of the costs, charges and expenses of winding up and for the adjustment of the rights of contributories among themselves, such amount as may be required, not exceeding $10.

Information on Directors

The following persons were Directors of the Australian College of Rural and Remote Medicine during this financial year. No payments (financial or otherwise) were made for their services.

Dr Sally Banfield
MBBS, FACRRM
Dr Banfield is the Registrar-elected director on the College Board. She has been involved in medical education and advocacy at both local and state levels. She has a passion for rural generalism and Indigenous health.
Dr Michael Beckoff
MBBS, FACRRM, FAICD, Assoc. Dipl. Agric (Dist)
Dr Beckoff is a practising rural generalist based in South Australia with 40 years experience, both as an equity partner and now as a rural and remote locum. He is a company director involved in various health corporate roles at a state and national level.

Dr Suzanne Harrison
MBBS, DA, FACRRM, MSP Medicine, Grad Cert Health Professional Education
Dr Harrison is a rural generalist in Echuca and part time medical educator for Melbourne University. She is a Board member of the Rural Workforce Agency Victoria, Rural Doctors Association of Australia and Murray City Country Coast GP Training.

Associate Professor Lachlan McIver
MBBS, MPH&TM, JCC (Anaes), FACRRM, FACTM, FAFPHM
Dr McIver is a rural generalist and public health physician with special interests in remote, indigenous and tropical health. Lachlan has spent the majority of his career working in rural communities around Australia and abroad, including several years with the World Health Organization, Medecins Sans Frontieres and Rocketship Pacific Ltd.

Professor Lucie Walters
PhD, MBBS, DCH, DipRACOG, FRACGP, FACRRM
Dr Walters is a practising rural generalist in obstetrics at Mt Gambier Hospital, South Australia. She is also a Professor of Rural Medical Education at Flinders Rural Health South Australia and Academic Coordinator of Parallel Rural Community Curriculum.

Dr Ewen McPhee
MBBS (Hons), FRACGP, FACRRM, DRANZCOG (Adv)
Dr Ewen McPhee is the current President of the Rural Doctors Association of Australia and is a rural generalist GP Obstetrician in private practice. As a long term resident of Emerald in Central Queensland, Dr McPhee has an interest in supporting the future rural medical workforce.

Associate Professor Ruth Stewart
MBBS, PhD(Flin), FACRRM, DRANZCOG
Dr Ruth Stewart is Associate Professor of Rural Medicine at James Cook University. She lives and works on Thursday Island. She is a Senior Medical Officer in the Thursday Island Hospital diabetes clinic and is a credentialed GP obstetrician. Ruth is Deputy Chair of the Torres and Cape York Hospital and Health Service Board.

Dr Daniel Halliday (appointed 20 June 2017)
MBBS, BBioMedSc, FACRRM, DRANZCOG, RACGP, GAICD, GCAHM
Dr Dan Halliday is a Rural Generalist with special interest in Obstetrics and Medical Superintendent of Stanthorpe Hospital, Queensland. Dan is a Past-President of Rural Doctors Association of Queensland (RDAQ) and is a past Director of Queensland Rural Medical Education (QRME). He is currently Secretary of the Rural Doctors Association of Queensland Foundation (RDAQF). Dan gained his GAICD in 2012.

Ms Marita Cowie
BA (Psych), BBus (Com), MEd (T&D)
Marita Cowie is the foundation Chief Executive Officer and Company Secretary of the College. She has more than 20 years experience in medical education, training and business management. Marita is also Deputy Chair of the Board of the Asthma Foundation of Queensland and New South Wales, and a Board member of Asthma Australia.

Meetings of directors
During the 2016–2017 financial year, seven meetings of Directors were held with attendance as follows:

<table>
<thead>
<tr>
<th>DIRECTORS</th>
<th>Directors Meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eligible to attend</td>
</tr>
<tr>
<td>Dr Michael Beckoff</td>
<td>7</td>
</tr>
<tr>
<td>Professor Lucie Walters</td>
<td>3</td>
</tr>
<tr>
<td>Associate Professor Lachlan McIver</td>
<td>4</td>
</tr>
<tr>
<td>Dr Sally Banfield</td>
<td>7</td>
</tr>
<tr>
<td>Dr Suzanne Harrison</td>
<td>7</td>
</tr>
<tr>
<td>Dr Ewen McPhee</td>
<td>7</td>
</tr>
<tr>
<td>Associate Professor Ruth Stewart</td>
<td>7</td>
</tr>
<tr>
<td>Dr Daniel Halliday</td>
<td>1</td>
</tr>
</tbody>
</table>

Attendance of ex officio board members at meetings of directors

<table>
<thead>
<tr>
<th>EX OFFICIO MEMBERS</th>
<th>Directors Meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eligible to attend</td>
</tr>
<tr>
<td>Associate Professor David Campbell, Censor in Chief</td>
<td>7</td>
</tr>
<tr>
<td>Ms Marita Cowie, Chief Executive Officer</td>
<td>7</td>
</tr>
<tr>
<td>Professor Lucie Walters, Immediate Past President</td>
<td>4</td>
</tr>
</tbody>
</table>
There is one formally constituted committee of the Board being the College Council. During the financial year four meetings of the Council were held with attendance as follows:

<table>
<thead>
<tr>
<th>COUNCIL MEMBERS</th>
<th>Council Meetings</th>
<th>Eligible to attend</th>
<th>Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Michael Beckoff</td>
<td></td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Professor Lucie Walters</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Associate Professor Lachlan McIver</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Dr Sally Banfield</td>
<td></td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Dr Suzanne Harrison</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Ms Marita Cowie</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Associate Professor David Campbell</td>
<td></td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Dr Ewen McPhee</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Professor Richard Murray</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Associate Professor Ruth Stewart</td>
<td></td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Dr Daniel Halliday</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Dr Rod Martin</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Dr Eve Merfield</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Dr Bruce Thorpe</td>
<td></td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Dr James Ricciardone</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Dr Justin Azzopardi</td>
<td></td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Dr Sarah Chalmers</td>
<td></td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Dr Michelle Hannan</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Dr Andrew Miller</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Dr Sally Singleton</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Dr Rob Phair</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

The Finance and Risk Management Committee during the financial year held five meetings with attendance as follows:

<table>
<thead>
<tr>
<th>FINANCE COMMITTEE MEMBERS</th>
<th>FINANCE COMMITTEE MEETINGS</th>
<th>Eligible to attend</th>
<th>Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Michael Beckoff</td>
<td></td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Associate Professor Lachlan McIver</td>
<td></td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Dr Bruce Thorpe</td>
<td></td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Dr Daniel Halliday</td>
<td></td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Dr Rob Phair</td>
<td></td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Ms Marita Cowie</td>
<td></td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Dr James Ricciardone</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Dr Ewen McPhee</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Auditor’s Independence Declaration

The lead auditor’s independence declaration under section 307C of the Corporations Act 2001 for the year ended 30 June 2017 has been received by the directors.

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

Director
Dated at Adelaide this twentieth day of September, 2017
AUDITOR'S INDEPENDENCE DECLARATION
UNDER SECTION 60-40 THE AUSTRALIAN CHARITIES AND NOT-FOR-PROFIT COMMISSION ACT 2012

TO THE DIRECTORS OF
AUSTRALIAN COLLEGE OF RURAL AND REMOTE MEDICINE LIMITED

I declare that, to the best of my knowledge and belief, during the year ended 30 June 2017 there have been:

(i) no contraventions of the auditor independence requirements as set out in the Australian Charities and Not-for-Profit Commission Act 2012 in relation to the audit; and

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

[Signature]
Bentleys Brisbane (Audit) Pty Ltd

[Signature]
Stewart Douglas
Director
Brisbane
20 September 2017
# Statement of Profit and Loss and Other Comprehensive Income

For the year ended 30 June 2017

<table>
<thead>
<tr>
<th>Notes</th>
<th>2017 ($)</th>
<th>2016 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues from Ordinary Activities</td>
<td>15,134,175</td>
<td>13,577,101</td>
</tr>
<tr>
<td>Expenses from Ordinary Activities</td>
<td>(14,522,352)</td>
<td>(13,002,130)</td>
</tr>
<tr>
<td>Surplus/(Deficit) from Ordinary Activities</td>
<td>611,823</td>
<td>574,971</td>
</tr>
<tr>
<td>Income Tax Expense</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Surplus/(Deficit)</td>
<td>611,823</td>
<td>574,971</td>
</tr>
<tr>
<td>Other comprehensive income</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Total comprehensive income for the year</td>
<td>611,823</td>
<td>574,971</td>
</tr>
</tbody>
</table>

The above Statement of Profit and Loss and Other Comprehensive Income should be read in conjunction with the attached notes.
# BALANCE SHEET

As at 30 June 2017

<table>
<thead>
<tr>
<th>Current Assets</th>
<th>NOTES</th>
<th>2017 $</th>
<th>2016 $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and Cash Equivalents</td>
<td>5</td>
<td>12,149,331</td>
<td>9,906,717</td>
</tr>
<tr>
<td>Trade and Other Receivables</td>
<td>6</td>
<td>945,423</td>
<td>698,572</td>
</tr>
<tr>
<td>Other Assets</td>
<td>7</td>
<td>315,511</td>
<td>334,342</td>
</tr>
<tr>
<td>Total Current Assets</td>
<td></td>
<td>13,410,265</td>
<td>10,939,631</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non Current Assets</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Intangible Assets</td>
<td>8</td>
<td>884,483</td>
<td>1,159,055</td>
</tr>
<tr>
<td>Plant and Equipment</td>
<td>9</td>
<td>104,063</td>
<td>114,263</td>
</tr>
<tr>
<td>Total Non Current Assets</td>
<td></td>
<td>988,546</td>
<td>1,273,318</td>
</tr>
</tbody>
</table>

| Total Assets                        |       | 14,398,811 | 12,212,949 |

<table>
<thead>
<tr>
<th>Current Liabilities</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade and Other Payables</td>
<td>10</td>
<td>8,657,358</td>
<td>7,154,000</td>
</tr>
<tr>
<td>Provisions</td>
<td>11</td>
<td>290,075</td>
<td>167,781</td>
</tr>
<tr>
<td>Other Liabilities</td>
<td>12</td>
<td>44,620</td>
<td>13,417</td>
</tr>
<tr>
<td>Total Current Liabilities</td>
<td></td>
<td>8,992,053</td>
<td>7,335,198</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non Current Liabilities</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provisions</td>
<td>11</td>
<td>189,887</td>
<td>272,703</td>
</tr>
<tr>
<td>Other Liabilities</td>
<td>12</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Total Non Current Liabilities</td>
<td></td>
<td>189,887</td>
<td>272,703</td>
</tr>
</tbody>
</table>

| Total Liabilities                  |       |  9,181,940 |  7,607,901 |

| Net Assets                         |       | 5,216,871  | 4,605,048 |

<table>
<thead>
<tr>
<th>Equity</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained Earnings</td>
<td>13</td>
<td>5,216,871</td>
<td>4,605,048</td>
</tr>
<tr>
<td>Total Equity</td>
<td></td>
<td>5,216,871</td>
<td>4,605,048</td>
</tr>
</tbody>
</table>

The above Balance Sheet should be read in conjunction with the attached notes.
# STATEMENT OF CASH FLOWS

For the year ended 30 June 2017

<table>
<thead>
<tr>
<th>Cash Flows from Operating Activities</th>
<th>NOTES</th>
<th>2017 $</th>
<th>2016 $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receipts from Members &amp; Other Consultancies</td>
<td></td>
<td>11,697,762</td>
<td>9,032,808</td>
</tr>
<tr>
<td>Interest Received</td>
<td></td>
<td>186,063</td>
<td>197,933</td>
</tr>
<tr>
<td>Grants Received</td>
<td></td>
<td>6,617,056</td>
<td>5,710,243</td>
</tr>
<tr>
<td>Payments to Suppliers and Employees</td>
<td></td>
<td>(16,201,212)</td>
<td>(13,527,829)</td>
</tr>
</tbody>
</table>

Net Cash (used in)/provided by Operating Activities 21(i) 2,299,669 1,413,155

<table>
<thead>
<tr>
<th>Cash Flows from Investing Activities</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments for Property, Plant, Equipment and Capital WIP</td>
<td>(57,055)</td>
<td>(134,346)</td>
<td></td>
</tr>
</tbody>
</table>

Net Cash (used in) Investing Activities (57,055) (134,346)

Net Increase (Decrease) in Cash held 2,242,614 1,278,809

Cash at the beginning of the Financial Year 9,906,717 8,627,908

Cash at the end of the Financial Year 21(ii) 12,149,331 9,906,717

The above Statement of Cash flows should be read in conjunction with the attached notes
# STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2017

<table>
<thead>
<tr>
<th></th>
<th>Retained Earnings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 30 June 2015</strong></td>
<td>4,030,077</td>
<td>4,030,077</td>
</tr>
<tr>
<td><strong>Comprehensive Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Surplus/(Deficit)</td>
<td>574,971</td>
<td>574,971</td>
</tr>
<tr>
<td>Other Comprehensive Income</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Comprehensive Income</strong></td>
<td>574,971</td>
<td>574,971</td>
</tr>
<tr>
<td><strong>Balance at 30 June 2016</strong></td>
<td>4,605,048</td>
<td>4,605,048</td>
</tr>
<tr>
<td><strong>Comprehensive Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Surplus/(Deficit)</td>
<td>611,823</td>
<td>611,823</td>
</tr>
<tr>
<td>Other Comprehensive Income</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Comprehensive Income</strong></td>
<td>611,823</td>
<td>611,823</td>
</tr>
<tr>
<td><strong>Balance at 30 June 2017</strong></td>
<td>$5,216,871</td>
<td>$5,216,871</td>
</tr>
</tbody>
</table>

The above Statement of Changes in Equity should be read in conjunction with the attached notes.
NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

1. SUMMARY OF ACCOUNTING POLICIES

These financial statements constitute a general purpose financial report which has been drawn up in accordance with Australian Accounting Standards (including other authoritative pronouncements of the Australian Accounting Standards Board and Australian Accounting Interpretations), the Corporations Act 2001 and the Australian and Not-for-Profits Commission Act 2012. The company is a not-for-profit entity for financial reporting purposes under Australian Accounting Standards.

A statement of compliance with International Financial Reporting Standards cannot be made due to the Company applying the not-for-profit sector specific requirements contained in Australian Accounting Standards.

Basis of Preparation

The financial statements, except for the cash flow information, are prepared on the accrual basis of accounting using the historical cost assumption and except where stated do not take into account changing money values nor current valuations of non current assets and their impact on operating results.

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

Critical Accounting Estimates and Judgments

The directors evaluate estimates and judgments incorporated into the financial statements based on historical knowledge and best available current information. Estimates assume a reasonable expectation of future events and are based on current trends and economic data, obtained both externally and within the company. Significant estimates and judgment employed by the company concern the useful life and depreciation rates for plant and equipment which are reviewed annually by the company (detailed in Note 1) and the basis of estimating the provision for make-good, detailed in Note 11.

Income Tax

The college is exempt from income tax under provisions of the Income Tax Assessment Act.

Property, Plant and Equipment

Property, plant and equipment are brought to account at cost, less, where applicable, any accumulated depreciation. Rates as per below:

<table>
<thead>
<tr>
<th>Depreciation method</th>
<th>Depreciation rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plant &amp; Equipment Purchased before 30/06/11</td>
<td>Diminishing value</td>
</tr>
<tr>
<td>Plant &amp; Equipment Purchased after 30/06/11</td>
<td>Straight Line</td>
</tr>
<tr>
<td>Leasehold Improvements</td>
<td>Straight Line</td>
</tr>
</tbody>
</table>

Revenue Recognition

(a) Non-reciprocal grant revenue is recognised in the statement of profit and loss and other comprehensive income when the entity obtains control of the grant and it is probable that the economic benefits gained from the grant will flow to the entity 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 entity 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 state of financial position as a liability until the service has been delivered to the contributor, at which time the grant is recognised as income.

(b) Interest Revenue is recognised on a time proportionate basis that takes into account the effective yield on the financial asset.

(c) Subscriptions are recognised on an accrual basis proportionate to when the service is provided.
Employee Benefits
The following liabilities arising in respect of employee entitlements are measured at the amount expected to be paid when the liability is settled:
- wages and salaries, annual leave and sick leave regardless whether they are expected to be settled within twelve months of balance date.
- other employee entitlements which are expected to be settled within twelve months of balance date.
Long service leave liabilities are determined after taking into consideration years of service, current level of wages and salaries and past experience regarding staff departures.

Leases
Lease payments for operating leases, where substantially all the risks and benefits remain with the lessor, are charged as expenses in the periods in which they are incurred.

Incentives received under lease arrangements are recognised in profit and loss over the term of the lease.

Intangible Assets
The cost of implementing a Customer Relationship Management System has been capitalised under the conditions set out in Australian Accounting Interpretations. The cost is to be amortised over a period of five years and any further expenses incurred for maintenance will be expensed in profit and loss.

Financial Instruments
Initial recognition and measurement
Financial assets and financial liabilities are recognised when the college becomes a party to the contractual provisions to the instrument. For financial assets, this is equivalent to the date that the company 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 in profit or loss immediately.

Classification and subsequent measurement
Financial instruments are subsequently measured at fair value, amortised cost using the effective interest rate method, or cost. Where available, quoted prices in an active market are used to determine fair value. In other circumstances, valuation techniques are adopted.

Amortised cost is calculated as the amount at which the financial asset or financial liability is measured at initial recognition less principal repayments and any reduction for impairment, and adjusted for any cumulative amortisation of the difference between that initial amount and the maturity amount calculated using the effective interest method.

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

Financial assets are derecognised when the contractual rights to receipt of cash flows expires or the asset is transferred to another party whereby the college no longer has any significant continuing involvement in the risks and benefits associated with the asset. Financial liabilities are derecognised where the related obligations are either discharged, cancelled or expired.

Fair value is determined based on current bid prices for all quoted investments. Valuation techniques are applied to determine the fair value for all unlisted securities, including recent arm's length transactions, reference to similar instruments and option pricing models. The net fair value of all financial assets and liabilities are represented by their book value unless otherwise stated.

(i) Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market and are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial asset is derecognised. Trade receivables represent the principal amounts outstanding at balance date, are non-interest bearing and are usually settled within 30 days.

(ii) Financial liabilities
Non-derivative financial liabilities other than financial guarantees are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial liability is derecognised.
Payables represent the principal amounts outstanding at balance date, are non-interest bearing and are usually settled within 30 days.

(iii) 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.

Derecognition
Financial assets are derecognised where the contractual rights to receipt of cash flows expires or the asset is transferred to another party whereby the college no longer has any significant continuing involvement in the risks and benefits associated with the asset. Financial liabilities are derecognised where the related obligations are either discharged, cancelled or expired.
Impairment of Assets
At the end of each reporting period, the college reviews the carrying values of its tangible and intangible assets to determine whether there is any indication that those assets have been impaired. If such an indication exists, the recoverable amount of the asset, being the higher of the asset's fair value less costs to sell and value in use, is compared to the asset's carrying value. Any excess of the asset's carrying value over its recoverable amount is recognised in profit or loss.

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

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.

Provisions
Provisions are recognised when the college 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.

New Accounting Standards Issued, Not Yet Effective
Certain new accounting standards and interpretations have been issued that are applicable for future reporting periods and have not been early adopted by the college. The college's preliminary assessment of the most significant of these new standards and interpretations is set out below:

AASB 15 – Revenue from Contracts with Customers
This standard takes effect for reporting periods beginning on or after 1 January 2018 and replaces standards AASB 118 Revenue, AASB 111 Construction Contracts and various Interpretations relating to revenue. AASB 15 introduces a 5-step process for recognising revenue based on identifying the performance obligations of contracts with customers and recognising revenue as and when those obligations are met.

The college is yet to conduct a detailed analysis of the impact of this standard, as most revenue is currently recognised under AASB 104 Contributions, and the college is awaiting further published guidance from the AASB on the recognition of revenue previously recognised under this standard.

AASB 16 – Leases
This standard takes effect for reporting periods beginning on or after 1 January 2019 and replaces AASB 117 Leases. The standard substantially changes the measurement criteria for operating leases, requiring them to be recognised in the statement of financial position. The college has not yet forecast the value of operating leases likely to be in place at the time the standard takes effect, but acknowledge that there is expected to be significant changes to the statement of financial position due to the total value of operating lease commitments that the college is currently party to. The college has not yet calculated what, if any, potential impact this change may have on the income statement, but the expectation from management is that it will be minimal.

AASB 9 – Financial Instruments
This standard takes effect for reporting periods beginning 1 January 2018 and replaces standards AASB 132 and AASB 139. The standard introduces some changes to hedging requirements, however as the college does not engage in hedging activities this is not expected to have a material impact. The standard also introduces some changes to naming conventions of certain financial assets and a new "expected credit losses" model for determining impairment. It is not expected this model will have a significant impact on impairment procedures for the college.

AASB 1058 – Income for Not-for-Profit Entities
This standard takes effect for reporting periods beginning on or after 1 January 2019 and replaces standard AASB 1004 Contributions.

Broadly, grants received for the purpose of acquiring or constructing a non-financial asset are recognised as a liability until the asset has been acquired or constructed.

In relation to grants that are more operational in nature, the standard requires they be assessed case-by-case as to whether they have specific ‘performance obligations’. If so, they are recognised as revenue when those obligations are met. If not, they will be recognised as revenue upon receipt. The college believes this is unlikely to have a significant impact as the requirements of the standard are consistent with the current revenue recognition policy of the college as described in Note 1.

There are no other standards that are not yet effective and that are expected to have a material impact on the entity in the current or future reporting periods and on foreseeable future transactions.

Fair Value Disclosures
The company does not measure any other assets or liabilities at fair value on a recurring basis after initial recognition. The carrying amount of financial assets and financial liabilities as disclosed in the statement of financial position and notes to the financial statements approximates their fair value.
### 2. REVENUES FROM ORDINARY ACTIVITIES

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rendering of Services</td>
<td>9,149,196</td>
<td>8,040,453</td>
</tr>
<tr>
<td>Grant Income</td>
<td>5,019,380</td>
<td>4,978,392</td>
</tr>
<tr>
<td>Sponsorship</td>
<td>769,248</td>
<td>341,773</td>
</tr>
<tr>
<td>Sundry Income</td>
<td>10,288</td>
<td>18,550</td>
</tr>
<tr>
<td>Non Operating Revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest</td>
<td>186,063</td>
<td>197,933</td>
</tr>
<tr>
<td></td>
<td><strong>15,134,175</strong></td>
<td><strong>13,577,101</strong></td>
</tr>
</tbody>
</table>

### 3. EXPENSES FROM ORDINARY ACTIVITIES

<table>
<thead>
<tr>
<th>Classification of Expenses by Function:</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>College Services &amp; Admin Expenses</td>
<td>9,437,682</td>
<td>7,963,946</td>
</tr>
<tr>
<td>Publication &amp; Communication Services</td>
<td>65,291</td>
<td>59,791</td>
</tr>
<tr>
<td>John Flynn Scholarship Scheme Grant Expenses</td>
<td>2,560,200</td>
<td>3,293,862</td>
</tr>
<tr>
<td>Bi-College Grant Expenses</td>
<td>153,258</td>
<td>26,183</td>
</tr>
<tr>
<td>GP Procedural Grant Expenses</td>
<td>271,079</td>
<td>291,433</td>
</tr>
<tr>
<td>Domestic Violence Grant Expenses</td>
<td>109,088</td>
<td>8,910</td>
</tr>
<tr>
<td>Chronic E-Health Grant Expenses</td>
<td>612,606</td>
<td>66,617</td>
</tr>
<tr>
<td>GP Anaesthetic Grant Expenses</td>
<td>552,311</td>
<td>868,481</td>
</tr>
<tr>
<td>Telehealth Grant Expenses (RHOF)</td>
<td>432,581</td>
<td>422,907</td>
</tr>
<tr>
<td>AGPT Selection Grant Expenses</td>
<td>118,147</td>
<td>-</td>
</tr>
<tr>
<td>jDocs Grant Expenses</td>
<td>4,928</td>
<td>-</td>
</tr>
<tr>
<td>GP Training Grant Expenses</td>
<td>205,181</td>
<td>-</td>
</tr>
<tr>
<td>Other Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Program Related Employee Benefits Expense</td>
<td>3,361,717</td>
<td>3,232,777</td>
</tr>
<tr>
<td>Program Related Employee Benefits Expense</td>
<td>1,136,187</td>
<td>914,093</td>
</tr>
<tr>
<td>Amortisation and Depreciation Expense</td>
<td>340,316</td>
<td>290,367</td>
</tr>
</tbody>
</table>
### 4. Surplus/(Deficit) from Ordinary Activities

<table>
<thead>
<tr>
<th>Description</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net (Gain)/Loss from sale of Plant and Equipment</td>
<td>1,511</td>
<td>322</td>
</tr>
<tr>
<td>Rental expense from operating leases</td>
<td>234,710</td>
<td>366,957</td>
</tr>
<tr>
<td>Superannuation contributions</td>
<td>285,843</td>
<td>268,441</td>
</tr>
</tbody>
</table>

### 5. Cash and Cash Equivalents

<table>
<thead>
<tr>
<th>Description</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash on Hand</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td>Cash at Bank</td>
<td>4,205,439</td>
<td>2,851,708</td>
</tr>
<tr>
<td>Cash on Deposit</td>
<td>7,943,692</td>
<td>7,054,809</td>
</tr>
<tr>
<td></td>
<td>12,149,331</td>
<td>9,906,717</td>
</tr>
</tbody>
</table>

### 6. Trade and Other Receivables

<table>
<thead>
<tr>
<th>Description</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade Receivable</td>
<td>945,423</td>
<td>698,572</td>
</tr>
</tbody>
</table>

Included in the above, are aggregate amounts receivable from the following related parties:

<table>
<thead>
<tr>
<th>Description</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directors (other than loans to directors)</td>
<td></td>
<td>2,714</td>
</tr>
</tbody>
</table>

### 7. Other Assets

<table>
<thead>
<tr>
<th>Description</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepayments</td>
<td>298,073</td>
<td>310,920</td>
</tr>
<tr>
<td>Accrued Income</td>
<td>17,438</td>
<td>23,422</td>
</tr>
<tr>
<td></td>
<td>315,511</td>
<td>334,342</td>
</tr>
</tbody>
</table>

### 8. Intangible Assets

<table>
<thead>
<tr>
<th>Description</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRM Development (at cost)</td>
<td>1,372,861</td>
<td>1,372,861</td>
</tr>
<tr>
<td>Accumulated Amortisation</td>
<td>(488,378)</td>
<td>(213,806)</td>
</tr>
<tr>
<td></td>
<td>884,483</td>
<td>1,159,055</td>
</tr>
</tbody>
</table>

**Movement in Intangible Assets**

<table>
<thead>
<tr>
<th>Description</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening Balance</td>
<td>1,159,055</td>
<td>-</td>
</tr>
<tr>
<td>Transferred from Capital Work-In-Progress</td>
<td>-</td>
<td>1,258,295</td>
</tr>
<tr>
<td>Additions</td>
<td>-</td>
<td>114,566</td>
</tr>
<tr>
<td>Disposals at Written Down Value</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Amortisation</td>
<td>(274,572)</td>
<td>(213,806)</td>
</tr>
<tr>
<td>Closing Balance</td>
<td>884,483</td>
<td>1,159,055</td>
</tr>
</tbody>
</table>
### 9. Property Plant and Equipment

<table>
<thead>
<tr>
<th></th>
<th>2017 ($)</th>
<th>2016 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Equipment (at cost)</td>
<td>338,392</td>
<td>287,744</td>
</tr>
<tr>
<td>Accumulated Depreciation</td>
<td>(234,329)</td>
<td>(188,151)</td>
</tr>
<tr>
<td>Total Property Plant and Equipment</td>
<td>104,063</td>
<td>99,593</td>
</tr>
</tbody>
</table>

#### Movement in Plant and Equipment

<table>
<thead>
<tr>
<th></th>
<th>2017 ($)</th>
<th>2016 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening Balance</td>
<td>99,593</td>
<td>131,547</td>
</tr>
<tr>
<td>Additions</td>
<td>57,055</td>
<td>19,780</td>
</tr>
<tr>
<td>Disposals at Written Down Value</td>
<td>(1,511)</td>
<td>(322)</td>
</tr>
<tr>
<td>Depreciation Expense</td>
<td>(51,074)</td>
<td>(51,412)</td>
</tr>
<tr>
<td>Closing Balance</td>
<td>104,063</td>
<td>99,593</td>
</tr>
</tbody>
</table>

#### Leasehold Improvements (at cost)

<table>
<thead>
<tr>
<th></th>
<th>2017 ($)</th>
<th>2016 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leasehold Improvements (at cost)</td>
<td>125,744</td>
<td>125,744</td>
</tr>
<tr>
<td>Accumulated Depreciation</td>
<td>(125,744)</td>
<td>(111,074)</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>14,670</td>
</tr>
</tbody>
</table>

#### Movement in Leasehold Improvements

<table>
<thead>
<tr>
<th></th>
<th>2017 ($)</th>
<th>2016 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening Balance</td>
<td>14,670</td>
<td>39,819</td>
</tr>
<tr>
<td>Additions</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Depreciation Expense</td>
<td>(14,670)</td>
<td>(25,149)</td>
</tr>
<tr>
<td>Closing Balance</td>
<td>-</td>
<td>14,670</td>
</tr>
</tbody>
</table>

#### Capital Work-In-Progress (CWIP) (at cost)

<table>
<thead>
<tr>
<th></th>
<th>2017 ($)</th>
<th>2016 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Work-In-Progress (CWIP) (at cost)</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

#### Transfer to Intangible Assets (CRM Development)

<table>
<thead>
<tr>
<th></th>
<th>2017 ($)</th>
<th>2016 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer to Intangible Assets (CRM Development)</td>
<td>-</td>
<td>(1,258,295)</td>
</tr>
<tr>
<td>Closing Balance</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Total Property Plant and Equipment**

<table>
<thead>
<tr>
<th></th>
<th>2017 ($)</th>
<th>2016 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Property Plant and Equipment</td>
<td>104,063</td>
<td>114,263</td>
</tr>
</tbody>
</table>
### 10. TRADE AND OTHER PAYABLES

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Current</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and Sundry Creditors</td>
<td>547,109</td>
<td>627,885</td>
</tr>
<tr>
<td>Unearned Income</td>
<td>7,257,096</td>
<td>5,314,507</td>
</tr>
<tr>
<td>Accruals</td>
<td>356,499</td>
<td>571,570</td>
</tr>
<tr>
<td>Employee Benefits (annual leave, salaries and PAYG)</td>
<td>325,402</td>
<td>423,598</td>
</tr>
<tr>
<td>GST Payable</td>
<td>171,252</td>
<td>216,440</td>
</tr>
<tr>
<td></td>
<td><strong>8,657,358</strong></td>
<td><strong>7,154,000</strong></td>
</tr>
</tbody>
</table>

Included in unearned income, are amounts from directors for memberships paid in advance: 7,250 3,850

### 11. PROVISIONS

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long Service Leave</td>
<td>290,075</td>
<td>167,781</td>
</tr>
<tr>
<td>Non-Current</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long Service Leave</td>
<td>43,437</td>
<td>126,253</td>
</tr>
<tr>
<td>Provision for &quot;Make Good&quot;</td>
<td>146,450</td>
<td>146,450</td>
</tr>
<tr>
<td></td>
<td><strong>189,887</strong></td>
<td><strong>272,703</strong></td>
</tr>
</tbody>
</table>

#### Analysis of Total Provisions

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
<td>290,075</td>
<td>167,781</td>
</tr>
<tr>
<td>Non-current</td>
<td>189,887</td>
<td>272,703</td>
</tr>
<tr>
<td>Total Provisions</td>
<td><strong>479,962</strong></td>
<td><strong>440,484</strong></td>
</tr>
</tbody>
</table>

The movement in the provision during the 2017 financial year is as follows:

<table>
<thead>
<tr>
<th></th>
<th>PROVISION FOR &quot;MAKE GOOD&quot; $</th>
<th>LONG SERVICE LEAVE $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening balance at 1 July 2016</td>
<td>146,450</td>
<td>294,034</td>
</tr>
<tr>
<td>Additional provisions raised during the year</td>
<td>–</td>
<td>42,843</td>
</tr>
<tr>
<td>Amounts used</td>
<td>–</td>
<td>(3,365)</td>
</tr>
<tr>
<td>Balance as at 30 June 2017</td>
<td>146,450</td>
<td>333,512</td>
</tr>
</tbody>
</table>
Provision for “Make Good”

A provision has been recognised for the requirement to restore the leased premises to their original condition at the conclusion of the lease term. The provision has been estimated using actual past experience with comparisons made to the experience of other similar organisations which generally fall between 30 to 50% of the annual rental expense. Management review the provision annually.

Provision for Non-current Employee Benefits

A provision has been recognised for employee entitlements relating to long service leave. In calculating the present value of future cash flows in respect of long service leave, the probability of long service leave being taken is based on historical data. The measurement and recognition criteria relating to employee benefits have been included in Note 1 to these financial statements.

12. OTHER LIABILITIES

<table>
<thead>
<tr>
<th></th>
<th>2017 $</th>
<th>2016 $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deferred lease incentive</td>
<td>44,620</td>
<td>13,417</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Current</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deferred lease incentive</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>44,620</td>
<td>13,417</td>
</tr>
</tbody>
</table>

13. RETAINED EARNINGS

<table>
<thead>
<tr>
<th></th>
<th>2017 $</th>
<th>2016 $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained Earnings at the beginning of year</td>
<td>4,605,048</td>
<td>4,030,077</td>
</tr>
<tr>
<td>Net Surplus/(Deficit)</td>
<td>611,823</td>
<td>574,971</td>
</tr>
<tr>
<td>Retained Earnings at the end of year</td>
<td>5,216,871</td>
<td>4,605,048</td>
</tr>
</tbody>
</table>

14. AUDITOR’S RENUMERATION

<table>
<thead>
<tr>
<th></th>
<th>2017 $</th>
<th>2016 $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit and review of Financial Statements</td>
<td>17,000</td>
<td>19,500</td>
</tr>
<tr>
<td>Other Project Audit Services</td>
<td>5,500</td>
<td>13,000</td>
</tr>
<tr>
<td></td>
<td>22,500</td>
<td>32,500</td>
</tr>
</tbody>
</table>

15. COMMITMENTS FOR EXPENDITURE

Operating Expenditure

<table>
<thead>
<tr>
<th></th>
<th>2017 $</th>
<th>2016 $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non cancellable operating lease for lease of premises</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commitments not provided for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No later than 1 year</td>
<td>268,761</td>
<td>237,491</td>
</tr>
<tr>
<td>Later than 1 year but no later than 5 years</td>
<td>806,283</td>
<td>1,113,627</td>
</tr>
<tr>
<td>Later than 5 years</td>
<td>–</td>
<td>25,266</td>
</tr>
<tr>
<td></td>
<td>1,075,044</td>
<td>1,376,384</td>
</tr>
</tbody>
</table>

The property lease commitments are non-cancellable operating leases contracted for but not recognised in the financial statements with a five-year term. Increase in lease commitments may occur in line with the Consumer Price Index (CPI).
16. MEMBER’S GUARANTEE

The company is limited by guarantee. If the company is wound up, the Articles of Association state that each member is required to contribute a maximum of $10 each towards meeting any obligations of the company.

17. CORPORATE INFORMATION

Australian College of Rural and Remote Medicine Limited is an Australian company incorporated and domiciled in Australia. Its principal activities are the provision of medical education and training services. The principal place of business and registered office of the Australian College of Rural and Remote Medicine Limited is Level 2, 410 Queen Street, Brisbane, Queensland. There are 54 employees (2016: 51) at the end of the reporting period.

18. SEGMENT INFORMATION

The company's sole business segment is the provision of medical, education and training services to rural and remote areas in Australia.

19. ECONOMIC DEPENDENCY

The project operations of the Australian College of Rural and Remote Medicine are dependent upon ongoing funding, which, to date, has been predominantly through agreements with the Department of Health.

20. RELATED PARTY TRANSACTIONS

Key management personnel comprises the directors and senior executive management team who have authority and responsibility for planning, directing and controlling the activities of the company.

The aggregate compensation of key management personnel is as follows:

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key management personnel compensation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- short-term benefits</td>
<td>949,539</td>
<td>752,589</td>
</tr>
<tr>
<td>- post-employment benefits</td>
<td>78,130</td>
<td>62,408</td>
</tr>
<tr>
<td>- other long-term benefits</td>
<td>5,470</td>
<td>3,512</td>
</tr>
<tr>
<td>Total</td>
<td>1,033,139</td>
<td>818,509</td>
</tr>
</tbody>
</table>

Of the above short-term benefits $79,481 (2016 : $46,014) relates to payments to directors for transactions made at arm’s length.

Other than those disclosed above and in note 10, there are no other related party transactions that occurred during the 30 June 2017 financial year (2016: nil).
### 21. NOTES TO THE STATEMENT OF CASHFLOWS

#### i) Reconciliation of Surplus/(Deficit) from Ordinary Activities after Income Tax to Net Cash Provided by Operating Activities

<table>
<thead>
<tr>
<th></th>
<th>2017 $</th>
<th>2016 $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus/(Deficit) from ordinary activities after income tax</td>
<td>611,823</td>
<td>574,971</td>
</tr>
<tr>
<td>Depreciation</td>
<td>65,744</td>
<td>76,561</td>
</tr>
<tr>
<td>Amortisation</td>
<td>274,572</td>
<td>213,806</td>
</tr>
<tr>
<td>Employee Entitlements</td>
<td>39,478</td>
<td>16,177</td>
</tr>
<tr>
<td>Loss/(Gain) on Disposal of Assets</td>
<td>1,511</td>
<td>322</td>
</tr>
<tr>
<td>(Increase)/Decrease in Receivables</td>
<td>(240,867)</td>
<td>(103,346)</td>
</tr>
<tr>
<td>Increase/(Decrease) Prepayments</td>
<td>12,847</td>
<td>61,677</td>
</tr>
<tr>
<td>Increase/(Decrease) Creditors &amp; Borrowings</td>
<td>1,534,561</td>
<td>572,987</td>
</tr>
<tr>
<td><strong>Net Cash Provided by Operating Activities</strong></td>
<td><strong>2,299,669</strong></td>
<td><strong>1,413,155</strong></td>
</tr>
</tbody>
</table>

For the purposes of the Statement of Cashflows, cash includes cash on hand and in banks and investments in money markets, net of bank overdrafts.

#### ii) Reconciliation of Cash

<table>
<thead>
<tr>
<th></th>
<th>2017 $</th>
<th>2016 $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash on Hand</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td>Cash at Bank</td>
<td>4,205,439</td>
<td>2,851,708</td>
</tr>
<tr>
<td>Cash on Deposit</td>
<td>7,943,692</td>
<td>7,054,809</td>
</tr>
<tr>
<td><strong>Net Cash Provided by Operating Activities</strong></td>
<td><strong>12,149,331</strong></td>
<td><strong>9,906,717</strong></td>
</tr>
</tbody>
</table>

#### iii) Undrawn Credit Card Facilities

<table>
<thead>
<tr>
<th></th>
<th>2017 $</th>
<th>2016 $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Limits at reporting date</td>
<td>255,000</td>
<td>265,000</td>
</tr>
<tr>
<td>Less: drawn at balance date</td>
<td>(84,729)</td>
<td>(106,103)</td>
</tr>
<tr>
<td><strong>Undrawn facilities at reporting date</strong></td>
<td><strong>170,271</strong></td>
<td><strong>158,897</strong></td>
</tr>
</tbody>
</table>

### 22. EVENTS AFTER THE BALANCE SHEET DATE

There have been no material events that have occurred since the end of the financial year.
23. FINANCIAL INSTRUMENTS

Financial Risk Management Policies

The Company’s financial instruments consist mainly of deposits with the banks, accounts receivable and accounts payable. The Company does not have any derivative instruments at 30 June 2017.

i) Treasury Risk Management

A finance committee meet on a regular basis to analyse financial risk exposure and to evaluate treasury management strategies in the context of the most recent economic conditions and forecasts.

The committee’s overall risk management strategy seeks to assist the Company in meeting its financial targets whilst minimising potential adverse effects on financial performance.

The finance committee operates under policies approved by the board of directors. Risk management policies are approved and reviewed by the Board on a regular basis. These include credit risk policies and future cash flow requirements.

ii) Financial Risk Exposures and Management

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

Interest rate risk

No assets or liabilities of the company bear interest except for cash and cash equivalents. The interest rate (market) risk regarding these assets is monitored by the directors to ensure the best possible financial returns.

At 30 June 2017 the weighted average effective interest rate in relation to cash and cash equivalents was 0.917% (2016 – 1.62%) with the interest rate being entirely represented by floating rates. In terms of interest rate sensitivity analysis, a 2% increase/decrease in interest rates would cause the net profit before tax and equity of the company to increase/decrease by $405,808 annually assuming all other variables remain constant.

Foreign currency risk

The company is not exposed to fluctuations in foreign currencies.

Liquidity risk

The company manages liquidity risk by monitoring forecast cash flows and ensuring that spending remains within approved project budgets for which funds are received in advance.

Credit Risk

The maximum exposure to credit risk, excluding the value of any collateral or other security, at balance date to recognised financial assets, is the carrying amount, net of any provisions for impairment of those assets, as disclosed in the balance sheet and notes to the financial statements.

There are no amounts of collateral held as security at 30 June 2017.

Credit risk arising from deposits with financial institutions is managed by the deposit of funds with authorised deposit taking institutions in Australia. The company is not exposed to any significant credit risk as its receivables are principally from commonwealth government grant funding or from members in respect of subscription and other assessment course services.
(iii) Carrying Amount of Financial Instruments by Category

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:

<table>
<thead>
<tr>
<th>FINANCIAL ASSETS</th>
<th>2017 $</th>
<th>2016 $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and cash equivalents</td>
<td>12,149,331</td>
<td>9,906,717</td>
</tr>
<tr>
<td>Accounts receivable and other debtors</td>
<td>945,423</td>
<td>1,478,131</td>
</tr>
<tr>
<td>Total Financial Assets</td>
<td>13,094,754</td>
<td>11,384,848</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FINANCIAL LIABILITIES</th>
<th>2017 $</th>
<th>2016 $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts payable and other payables</td>
<td>547,109</td>
<td>627,885</td>
</tr>
<tr>
<td>Total Financial Liabilities</td>
<td>547,109</td>
<td>627,885</td>
</tr>
</tbody>
</table>

(iv) Financial liability and financial asset maturity analysis:

- Trade receivables represent the principal amounts outstanding at balance date, are non-interest bearing and are usually settled within 30 days.
- All other receivables are due to be received within one year.
- Trade payables represent the principal amounts outstanding at balance date, are non-interest bearing and are usually settled within 30 days.
- All other payables are due for payment within one year.

(v) Net Fair Value of Financial Instruments is equal to or approximately equal to their carrying amount.

24. CONTINGENT LIABILITIES

The college has no contingent liabilities at 30 June 2017 (2016: nil).
DIRECTORS DECLARATION

In accordance with a resolution of the Directors of the Australian College of Rural and Remote Medicine Limited, the Directors declare that:

1. The financial statements and notes as set out on pages 7 to 22 are in accordance with the Corporations Act 2001 and the Australian Charities and Not-for-Profit Commission Act 2012 and:
   (a) comply with Australian Accounting Standards; and
   (b) give a true and fair view of the company’s financial position as at 30 June 2017 and its performance for the year ended on that date.

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

Signed in accordance with a resolution of the Directors.

[Signature]

Director
Dated at Adelaide, this twentieth day of September, 2017
INDEPENDENT AUDITOR’S REPORT
TO THE DIRECTORS OF AUSTRALIAN COLLEGE
OF RURAL AND REMOTE MEDICINE LIMITED


Opinion

We have audited the accompanying financial report of Australian College of Rural and Remote Medicine Limited (“the company”), which comprise the Balance Sheet as at 30 June 2017 and 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, a summary of significant accounting policies and other explanatory notes and the directors’ declaration.

In our opinion the financial report of Australian College of Rural and Remote Medicine Limited is in accordance with Division 60 of the Australian Charities and Not-for-Profits Commission Act 2012, including:

a) giving a true and fair view of the company’s financial position as at 30 June 2017 and its financial performance for the year then ended; and

b) complying with Australian Accounting Standards and Division 60 of the Australian Charities and Not-for-Profits Commission Regulation 2013.

Basis of opinion

We conducted our audit in accordance with Australian Auditing Standards. Our responsibilities under those standards are further described in the Auditor’s Responsibilities for the Audit of the Financial Report section of our report. We are independent of the company in accordance with the ethical requirements of the Australian Professional and Ethical Standards Board’s APES 110 Code of Ethics for Professional Accountants (the Code) that are relevant to our audit of the financial report in Australia. We have also fulfilled our other ethical responsibilities in accordance with the Code.

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

Directors’ Responsibility for the Financial Statements

The directors are responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the Australian Charities and Not-for-Profits Commission Act 2012, and for such internal control as the directors determine is necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error.

In preparing the financial report, the directors are responsible for assessing the ability of the company to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the company or to cease operations, or has no realistic alternative but to do so.

The directors are responsible for overseeing the company’s financial reporting process.
Auditor's Responsibility

Our objectives are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

As part of an audit in accordance with Australian Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the company's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the directors.

- Conclude on the appropriateness of the directors' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the company's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Company to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.
INDEPENDENT AUDITOR’S REPORT
TO THE DIRECTORS OF AUSTRALIAN COLLEGE
OF RURAL AND REMOTE MEDICINE LIMITED (CONTINUED)

Auditor’s Responsibility (Continued)
We communicate with the Directors regarding, among other matters, the planned scope and
timing of the audit and significant audit findings, including any significant deficiencies in internal
control that we identify during our audit.

Bentleys

Bentleys Brisbane (Audit) Pty Ltd

Stewart Douglas
Director
20 September 2017
Brisbane