



Australian College of
Rural and Remote Medicine

Annual Report
2005 - 2006

Recognising Rural and Remote Medicine

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ACRRM's Annual Report is intended to provide a brief introductory overview of ACRRM for the financial year 2005 - 2006.

Australian College of
Rural and Remote Medicine

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ANNUAL REPORT
2005 - 2006



ACRRM Board Members

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I President's Report

The End of the Beginning.....



“This year we have been able to move towards finalisation of the structure and program of our assessment for Fellowship.”

For the past decade, the Australian College of Rural and Remote Medicine has worked tirelessly to ensure that the medical education system in Australia produces enough doctors with the right skills to meet the needs of Australia's rural communities.

This effort has been directed at several levels. Our core business has been in the development and recognition of the discipline of Rural and Remote Medicine. To this end we have had our curriculum and training program in place for some time; and this year we have been able to move towards finalisation of the structure and program of our assessment for Fellowship.

In addition, ACRRM is increasingly being looked to as the appropriate organisation to support and provide input to all levels of rural medical training, as outlined in more detail in this report.

In this light, it is my great pleasure to bring to you ACRRM's annual report for the 2005-2006 year. May I begin by paying tribute to our Immediate Past President, Bruce Chater. Bruce brought to the Presidency a wealth of experience and understanding of rural medical politics and in many ways exemplified the passion of rural doctors across Australia. During his term, ACRRM experienced a rapid growth in recognition, membership and support from government, and many of ACRRM's successes, both small and large, in recent times occurred as a result of Bruce's dedication and commitment to rural Australia.

Soon after the 2005 Annual General Meeting, we finalised our submission to the Australian Medical Council (AMC) for recognition of Rural and Remote Medicine as a medical speciality. This submission was the culmination of an immense sustained effort over the previous 18 months, at considerable expense to our organisation. Nearing the end of this process, it became clear that the AMC did not have the mechanism, nor precedent, for recognition of a non-referred speciality, despite having accepted our submission. Ultimately, this was one of the factors in the failure to achieve recognition.

On 22 December 2005, Federal Health Minister Tony Abbott released the AMC's findings, but took the step of acknowledging the importance of the college and its role in "providing educational and professional support" for doctors in rural and remote Australia, and invited ACRRM to apply to the AMC for accreditation of its education and assessment programs.

To support the college, the Minister announced the provision of \$1 million to engage a series of consultants to meet the AMC accreditation requirements and for general assistance in the application process.

In early 2006, the Health Minister wrote again to ACRRM stating that achieving AMC Initial Accreditation would enable regulation changes within the Health Insurance Act to create a Register of ACRRM Fellows. This will ensure independent access to MBS rebates for ACRRM Fellows, as well as provide the FACRRM end-point to Registrar training under the Australian General Practice Training Program (GPET).

During the year, the Australian Medical Association wrote to ACRRM to advise that their Federal Council had passed a formal resolution acknowledging ACRRM's important work in the training of rural and remote medical practitioners, and its right to apply for accreditation with the AMC. This endorsement exemplified the increased appreciation and acceptance of ACRRM within the medical community.

At the same time, it became clear that the rural medical workforce crisis was worsening. Individual states were expanding their recruitment and support initiatives to address both the skill shortage and the increased demand for rural medical services. With limited practitioners available in Australia, many states spent extensive resources on recruitment efforts during the year to attract overseas doctors.

With an eye to longer term strategies, ACRRM continued to receive commonwealth government support with the Rural Medical Bonded Scholars program, the John Flynn Scholarship Program and the Prevocational General Practice Placement Program. These programs are aimed at recruitment of local students and recent graduates to rural medicine, and the signs are that they are working (see below).

On numerous occasions during 2006, I made it a priority to meet with and write to health ministers and leading government officials to promote the benefits to each state of recognising rural and remote medicine in health legislation. The role of state health departments, postgraduate medical councils and state medical boards is crucial to recognition and support of rural and remote medicine.

Hence the decision in July 2006 by the Council of Australian Governments to give 'rural medicine' formal recognition under Medicare, as a generalist discipline, from April 2007, consequent on AMC Accreditation, is a critical milestone for ACRRM. To this end, ACRRM will continue to work closely with GPET to ensure implementation of our training program from 2007 onwards.

Membership

ACRRM's membership base has grown steadily to more than 2000, which represents around 50% of the rural and remote medical practitioners currently practising throughout Australia. Additionally, ACRRM has noted a dramatic increase in interest from recent graduates, long-term practitioners, students, and overseas trained doctors inquiring about membership matters and about the college's application for recognition as an accredited medical college with the AMC.

Strategic direction

At the end of 2005, and during 2006, the ACRRM Board and senior staff met to prepare the college's Strategic Plan for 2006-2008. The plan developed a number of objectives and strategies to ensure the college effectively meets the needs of its current and future members, and maintains the highest possible levels of financial and operational standards.

College Programs

Student and junior doctor programs

Research clearly indicates to us that current rural practitioners are getting older and rapidly making their way towards a point where they will slow down, diminish their working hours, or retire altogether. Many rural practitioners continue well past 65 often because they know no one will replace them. ACRRM staff never cease to be amazed when a Fellow contacts the college to announce his or her retirement ... at age 80 or more.

Succession planning for Australia's ageing cohort of rural doctors is a critical issue. Future generations of medical graduates must be readied for rural practice, and the College's student and junior doctor programs are therefore vital in providing encouragement and training to young practitioners, if they are to go on to rural and remote medicine.

ACRRM continued to support the next generation of rural doctors through its administration of the John Flynn Scholarship Scheme (JFSS), Medical Rural Bonded Support Scheme (MRB Support) and Prevocational General Practice Placement Program (PGPPP), and was greatly encouraged by the demand for these programs among both rural and metropolitan medical students. These schemes provide effective training and/or educational support to undergraduates and recent graduates with an interest in rural medicine. The combination of mixing with rural communities, mentor opportunities, support for attendance at rural medical conferences and first-hand experience of

rural practice are crucial elements of these programs, with good evidence in Australia and overseas that such initiatives have a positive impact on rural workforce. ACRRM's on-going evaluation of these programs supports these findings.

Rural and Remote Medical Education Online

ACRRM has once again shown its leadership in the field of medical distance education and support with the new and improved version of the College's online education platform, Rural and Remote Medical Education Online (RRMEO), launched in June 2006. The upgrade greatly improved design and user friendliness and included new features for the more than 5,000 active users.

Education and training

The College's education and training areas have also experienced strong growth. Demand for ACRRM's Professional Development Program, which maintains professional standards and reporting requirements for doctors, achieved enrolments exceeding 1,500 and also experienced unprecedented demand for accreditation of activities by education providers.

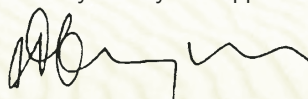
Vocational training enjoyed steady growth with more than 100 registrars now preparing specifically for a career in rural and remote medical practice. Training activities for rural practice were bolstered by two significant announcements during the year: the COAG decision to recognise rural medicine within Medicare legislation (discussed earlier); and Queensland Health's decision to implement a Rural Generalist Training Program within hospitals and to support registrars towards a FACRRM qualification.

The College also continued to build on its strength and commitment to procedural medicine skills by administering the Commonwealth Government's Training for Rural and Remote Procedural GP Program. This program supported 624 rural doctors to attend upskilling for procedural practice, and disbursed more than \$6.5 million of funding under the scheme.

In summary, it has taken nearly a decade since the birth of ACRRM to achieve general acknowledgement within the medical community. From significant sections of the profession, the recognition and support was immediate and sustained. Support from other parts of the complex professional, bureaucratic and industrial structure of Australian medical practice has taken longer.

But we have reached the end of our beginning. As ACRRM moves into the next phase of its existence, new challenges will arise. The reality of significantly increased numbers within our training programs, emerging with a recognised qualification, seeking credentialing for their skills, requiring up-skilling and continued support, combined with the increasing pressure for more targeted and efficient training pathways towards competent rural practice, will continue to focus our endeavours. As one senior, experienced state health bureaucrat said to me recently, "If you've got an organisation that wants to make a difference, why wouldn't you support it?" ACRRM will continue to make a difference.

Thank you for your support.



David Cambell
President

CEO's Report

I am pleased to report that the 2005-2006 year has again been a very successful one for ACRRM with the College making considerable progress on critical issues including recognition of the discipline of Rural and Remote Medicine, assessment for Fellowship and support for procedural rural doctors.

During the period, we have focused on extending the services and products we offer to meet the needs of our members, growing the business and strengthening our national presence. A critical element of this process has been our campaign to achieve recognition of the discipline of Rural and Remote Medicine through the Australian Medical Council (AMC).

Following a long and demanding assessment process by the AMC in 2004/05, the Government agreed to recognise Rural and Remote Medicine as a "distinct discipline" within the specialty of general practice. Furthermore, the College impressed upon the Government that it was making an important and significant contribution to the rural medical workforce and the Minister for Health and Ageing, the Hon Tony Abbott, agreed to provide ACRRM with special funding of \$1 million to assist us to accelerate the completion of our assessment process for Fellowship. This allowed ACRRM to apply for Initial Accreditation of its programs via the Specialist Education Accreditation Committee of the AMC – the final requirement for fully recognising the discipline and the College.

In parallel with this academic assessment of Rural and Remote Medicine, ACRRM has been working with the state and federal Governments to provide pathways that would allow very practical workforce and quality rural practice outcomes. As a result, the Council of Australian Governments (COAG) agreed that "in order to attract more general practitioners with procedural skills to rural areas, and subject to the Australian College of Rural and Remote Medicine's training program being accredited by the Australian Medical Council, the Commonwealth will provide rural medicine with formal recognition under Medicare as a generalist discipline by April 2007."

We have also made a landmark agreement with the Queensland Government to work with Queensland Health to establish a "Rural Generalist Training Pathway" for hospital based rural medical generalists. This will provide a FACRRM training option for doctors who wish to pursue a procedural rural medical generalist qualification that is vocationally recognised (subject to approval of ACRRM's programs by AMC) and primarily based in small rural hospitals.

Our assessment requirements for Fellowship are now in their final stages of development and trialling. We have aimed to meet all of the academic requirements in a way that is rigorous yet still flexible and extremely relevant to rural doctors. We anticipate that all assessment requirements will be in place and apply to registrars enrolling from 2007 onwards.

The College has always had a very strong commitment to personal service and support. Our staff are our most important asset – they are knowledgeable, well informed and helpful and provide the highest possible service to our doctors.

These are important outcomes and services for our members and I am proud to report that they have been delivered on all counts during the year.



"ACRRM has been working with the state and federal Governments to provide pathways that would allow very practical workforce and quality rural practice outcomes."

Key developments

Membership	<ul style="list-style-type: none"> • Membership has exceeded 2000. Increases in stronger eastern states but also, pleasingly, in the west. • Series of member consultation meetings held in regional centres of each state. • Communications survey of members and stakeholders conducted to refine the way in which information is provided by the College.
Recognition	<ul style="list-style-type: none"> • Following AMC assessment, Government has recognised RRM is a distinct discipline within the specialty of general practice and invited ACRRM to apply for Initial Accreditation of its training and professional development programs. • COAG announcement that rural medicine will be recognised in the Medicare legislation, subject to AMC accreditation. • Queensland Health recognition of 'rural medical generalist' and introduction of the 'Rural Generalist Training Program' in 2007.
Professional development	<ul style="list-style-type: none"> • 1,500 members enrolled in PDP • 1,191 of PDP participants use the program to maintain their VR requirements under Medicare. • Compliance rate for VR maintenance of 100% for the triennium and an overall compliance rate of 99% achieved for the 2002-2004 triennium.
Vocational training	<ul style="list-style-type: none"> • Registrar numbers increased to 109. • 8 Regional Training Providers are fully accredited to deliver FACRRM, another four are partway through the process. • Curriculum and implementation work has commenced with Queensland Health to establish the new Rural Generalists Pathway for 2007.
Students & Junior doctors	<ul style="list-style-type: none"> • High level of engagement with more than 1,100 students and junior doctors via the JFSS, MRB and PGPPP programs. • Work commenced on integration of undergraduate, prevocational and vocational training curricula.
On-line services	<ul style="list-style-type: none"> • RRMEO continues to lead the world in online services and systems for medical education. • New generation of RRMEO launched in June 06 to improve navigation and functions throughout site. • Increase in users, including other specialist colleges. • Increase in products and modules.
Procedural medicine	<ul style="list-style-type: none"> • ACRRM continues to lead the major procedural medicine support program in Australia. • 624 doctors provided with \$6,581,000 in financial support to maintain their procedural skills throughout the year via the Training for Procedural Rural and Remote GPs Program. • Ultrasound, radiology and emergency medicine workshops held regionally in high need areas.

Acknowledgements

ACRRM's growth relies on the sustained energy and loyalty of people that continue to drive the agenda of rural and remote health forward, often in uncharted territories. The close collaborative working relationship between Board, staff and members generates ACRRM's distinctive work culture and it is a privilege to be part of such a committed and forward thinking team.

The future

The last 12 months has seen ACRRM finally pass through the doorway leading to greater recognition of the importance of educating, supporting and encouraging current and future Australian doctors to consider Rural and Remote medical practice. Choosing the right path and getting to where we are now has been an exciting and challenging activity for the College for nine years.

During the next 12 months we aim to continue to consolidate and refine the training and assessment programs, to stabilise our business and role within the medical education sector, and importantly, to continue to respond to the changing needs of our members. This will see further work in standards, and safety and quality in practice issues as well as strong representation on key issues at regional, state and national levels. We also have a strong and ongoing commitment to innovation in our programs and increased delivery of resources that are relevant and beneficial for rural doctors, their practice and the health of their communities.

I would like to take this opportunity to give my thanks to the hard work of the College Board, staff and members, and the commitment of the state and federal Governments towards recognition of the importance of our objectives. We can now be confident that many more doors will open for us into the future.



Marita Cowie
CEO



Professional Development Program Report

Review

The last twelve months has seen a continuation of the organisational, operational and policy review commenced in 2005 in the ACRRM Professional Development Program (PDP). A major overview of the policies and procedures was undertaken by an external quality assurance assessment organisation, and protocols and quality assurance processes developed across all PDP activities.

This review has facilitated improvements in the operational systems for PDP and increased capacity to process attendance lists and PDP certificates. The result has been improved efficiency and accuracy in the allocation of PDP points into members' statements.

Membership

Participation in ACRRM's PDP for reporting of Vocational Recognition increased during the period by 8.9%.

PDP Registrations	VR & FACRRM Maintenance	VR Maintenance Only	FACRRM Maintenance Only	Third Party Reporting
1 July 2005	956	142	299	1103
30 June 2006	1002	194	314	1191

During the period there was also a significant increase in the number of ACRRM members requiring third party reporting (for example, to meet the requirements of other medical colleges) across a broad range of specialist areas. Within the 12 month period, the number of members requiring ACRRM to report for third party purposes increased by 7.9%.

Third Party Reporting	Mental Health	Obstetrics & Gynecology	Acupuncture	Radiology	Anaesthetics
1 July 2005	302	307	47	232	215
30 June 2006	327	334	53	246	231

Professional Development Activities

The number of education providers seeking ACRRM accreditation has also increased significantly in the past twelve months. By the end of June 2006, there was a 34% increase in external providers accrediting activities with ACRRM.

The number of activities listed on ACRRM's educational inventory increased by 225%, providing an extensive range of continuing education activities to ACRRM members.

Annual Figures 01/07/2005 - 30/06/2006	Educational Activities	Registered Providers
1 July 2005	914	253
30 June 2006	2969	334
Increased by	225%	24%

Triennium Figures	Educational Activities	Registered Providers
Total providers/activities for triennium 2002-2004	1168	249
Total providers/activities for triennium 2005-2007 to date	2969	334
Increased this triennium by	154%	34%

Rural and Remote Medical Education Online (RRMEO)

RRMEO underwent a major redevelopment during the past twelve months. The upgrade has greatly increased the usability and efficiency of RRMEO for both members and staff for the management of the PDP area and its online activities.

Ultrasound Program

During the period, ACRRM conducted a series of obstetric ultrasound workshops in various locations across Australia as part of a program funded by the Australian Government. The obstetric ultrasound program was an ACRRM initiative to help meet the specific education needs of rural doctors that performed obstetric services in their community. These workshops continued to be popular in 2005-2006 and were fully booked on each occasion during the period, providing training to close to 100 practitioners. Workshops were conducted in Moruya (September 2005), Adelaide (November 2005), Bendigo (February 2006), Darwin (April 2006), and Bunbury (June 2006).

Committee

Dr Stephen Holmes continued his role as Chair of the PDP Committee, which held a membership of 10. The Committee experienced some changes over the year, with Drs Bruce Cameron, Fred McConnel and Greg Whittaker having left the committee. We greatly thank them for their contribution. Replacement committee members included Dr Richard Murray (College Censor) and Dr Greg Murphy.

Staff

During the past year the PDP area had operated at the regional and central level. Twelve Regional Support Officers (RSO's) had been based at a State and Territory level to provide support for members in regard to PDP activities. Activities such as program and committee support, policy development and implementation, accreditation, and recording and reporting were carried out centrally. The RSO positions were funded under a grant from the Federal Department of Health and Ageing, which concluded on 30 June 2006. This facilitated in a review of PDP staffing and operations.



Vocational Training Report

Recognition

The vocational training area of ACRRM aims to support and train doctors that are safe, independent and confident generalist practitioners capable of working anywhere in Australia, including the diverse range of rural and remote settings.

In the period 2005-2006, ACRRM built upon the success of the previous 12 months to further the recognition of ACRRM training pathways and models for training towards the Fellowship of ACRRM (FACRRM). Extensive work was conducted with the Australian Medical Council (AMC) and Council Of Australian Governments (COAG) in presenting the case for the recognition of Rural and Remote Medicine as a unique field within the discipline of generalist practice, and a great deal of input was provided for the Forster Review and in establishing recognition of the Rural Generalist career pathway within Queensland Health. Additionally, ACRRM further developed its relationship with the Commonwealth agency responsible for managing the training of GPs, General Practice Education and Training (GPET), and worked with GPET and the Rural Vocational Training Scheme (RVTS) in the implementation of the FACRRM via the network of ACRRM accredited regional training providers (RTPs).

Accreditation

In 2005-2006, processes and accreditation procedures were developed to ensure quality of training against ACRRM standards within the RTP network. GPET formally recognised these ACRRM standards and processes for the accreditation of practices and posts and incorporated the ACRRM standards for recognition of RTPs as an option for rural RTPs within the GPET accreditation process. The Enhanced Rural Training Framework was also introduced by GPET to provide RTPs with advice and additional resources to fully support registrars seeking the FACRRM.

A critical component of the Enhanced Rural Training Framework is the requirement and funding for the appointment of ACRRM advisors. During the year, ACRRM accredited RTPs were required to appoint an experienced rural doctor that is a Fellow of ACRRM and who meets the ACRRM requirements for this position. This network of experienced rural medical practitioners assisted in providing regional support and advice to FACRRM candidates. The following Fellows were selected during the period as medical advisors.

Regional Training Provider	Nominated ACRRM Advisor
Adelaide to Outback Training Program	Dr Tim Kelly
Bogong Regional Training Network	Dr Peter Keppel
Central and Southern Qld Training Consortium	Dr Kathy Kirkpatrick
CoastCityCountry Training Ltd	Dr Robert Wiles
General Practice Training Tasmania	Dr Natalie Burch
Gippsland Education & Training (getGP)	Dr Peter Stevens
GPLogic (Central West / RhedWest)	Dr Sandra Mendel
Greater Green Triangle GP Education & Training	Dr Antony Wong
New England Area Training Services Ltd	Dr John Fraser
Rural & Regional Qld Consortium	Dr Bill Lang (Temp)
Sturt Fleurieu General Practice Education & Training	Dr Peter Clements
Tropical Medical Training	Dr Robert Thompson
Victoria Felix Medical Education	Dr George Somers
WA General Practice Education & Training	Dr Michael Eaton

ACRRM registrar participants

ACRRM has established models/pathways providing candidates with three options for meeting FACRRM requirements: Independent Pathway, Vocational Preparation Pathway, and RVTS. The number of registrars formally participating in ACRRM pathways increased significantly in 2005-2006.

As at 30 June 2006, the following numbers had been recorded for each pathway scheme.

Vocational Preparation Pathway:	80
Independent Pathway:	20
RVTS Pathway:	9
Total	109

ACRRM Accreditation of teaching posts and practices

During the period, training was conducted in ACRRM accredited rural training posts and practices, and delivered by accredited supervisors. Posts accredited included eligible aboriginal medical services, rural and metropolitan hospitals, rural general practices, and RFDS positions.

Practices were assessed by accredited ACRRM surveyors reporting to both the Board of Censors and the RTP As at 30 June 2006, 190 practice sites/training posts had been accredited by ACRRM, or were in the process of being accredited, an increase of 70 practices from the same time last year. This number is expected to increase as more RTPs delivering FACRRM come on line.

ACRRM accreditation of Regional Training Providers

The first round of the GPET RTP accreditation was finalised in June 2006. RTPs seeking ACRRM recognition for delivering FACRRM were required to register with ACRRM, complete a self assessment against ACRRM standards, and participate in the accreditation process managed by GPET.

ACRRM was also pleased to participate in the review of processes and procedures for the round two accreditation cycle, which started in June 2006 and will continue to 2009.

Figure 2: Breakdown of Regional Training Provider Accreditation Status as at 30 June 2006

Regional Training Provider	Accreditation Status
Adelaide to Outback Training Program	Fully accredited round 1
Bogong Regional Training Network	Registered for round 2
Central and Southern Qld Training Consortium	Fully accredited round 1
Central West Regional GP Training Consortium	Fully accredited round 1
CoastCityCountry Training Ltd	Registered for round 2
General Practice Training Tasmania	Registered for round 2
General Practice Training Valley to Coast	Fully accredited round 1
Gippsland Education & Training (getGP)	Fully accredited round 1
Greater Green Triangle GP Education & Training	Registered for round 2
New England Area Training Services Ltd	Self-assessment received
North Coast GP Training Ltd	Not registered to date
Northern Territory General Practice Education	Not registered to date
Rural & Regional Qld Consortium	Fully accredited round 1
Sturt Fleurieu General Practice Education & Training	Fully accredited round 1
Tropical Medical Training	Self-assessment received
Victoria Felix Medical Education	Fully accredited round 1
WA General Practice Education & Training	Fully accredited round 1



I Pre-vocational General Practice Placements Program

The Prevocational General Practice Placements Program provides supervised placements for junior doctors in remote, rural and small regional locations and is seen as an important link in the vertical integration of rural training, between rural students and rural career pathways. Through the program, junior doctors are provided the opportunity to experience rural community practice in their intern and resident years. While the program is funded by the Australian Government, it is appropriate that ACRRM plays a leading role in this program to assist in providing this 'hands on' work experience to this key group of future doctors.

During the 2005-2006 period, ACRRM continued to provide the secretariat services for the PGPPP and to act as Managing Organisation for the rural and remote component of the program, disbursing more than \$20m in grants to regional training sites. During this time ACRRM was also responsible for overseeing a major expansion of the program in terms of training places and national profile.

ACRRM continued to play a crucial role in promoting the program to potential participants and much sought after medical practitioner supervisors. A range of promotional materials and newsletters were developed and distributed to target groups, or displayed at key medical conferences including the National GPET conference, Australian Divisions of General Practice conference, the National Prevocational Medical Education Forum (for post graduate medical students), Rural Workforce Agency and Rural Doctors Association conferences, and ACRRM's own Orientation to Rural and Remote Medicine weekend.

As at 30 June 2006, ACRRM managed training placements for 130 junior doctors in 32 rural and remote locations. In addition, the Department of Health and Ageing had authorised the secretariat to administer a separate Internal Evaluation Project to run until June 2007 which will develop effectiveness ratings for the training program and track the career destinations of participants in the PGPPP on behalf of ACRRM and the RACGP.

ACRRM and the PGPPP team would like to take this opportunity to thank all doctors, medical practices, hospitals, and rural organisations involved in the PGPPP for playing a part in this important national program.

John Flynn Scholarship Scheme



The John Flynn Scholarship Scheme (JFSS) aims to increase the number of doctors pursuing rural and remote medical careers by facilitating the formation of relationships between medical students and rural communities, and giving students a taste of what life is like practicing medicine in rural and remote Australia. Scholars undertake annual two week placements in a rural community, and this will continue for each scholar over a four year period. As at 30 June 2006, the JFSS scheme provides financial and or administrative support to nearly 600 scholarship holders.

During the second half of 2005, the John Flynn scholarship team underwent an exhaustive process of matching scholars with suitable mentors in practices and areas as close as possible to the scholars' interests. This process followed an extensive interview and selection stage where representatives from rural practice, medical faculties, student groups, and rural communities were brought together to select the new crop of scholars.

Over the 2005-2006 Christmas period, approximately 300 scholars undertook placements in various parts of Australia, with many of the new cohort experiencing rural life and rural medicine for the first time.

In early 2006, 150 new students were awarded John Flynn scholarships. These scholars are to undertake their first placement in the second half of 2006 or early in 2007.

Also early in the year, ACRRM commenced the development and operation of a tracking system aimed at gathering data on the training and career preferences of current and former John Flynn scholars. The intention of the tracking system is to test the proposition that participating in the JFSS contributed to a student's rural career intentions. Pleasingly, early data indicated John Flynn scholars demonstrate a propensity towards working and training in rural or remote locations.

The JFSS evaluation system underwent a series of changes in early 2006, including revised evaluation forms and new methods of data collection and management. This has led to an increase in response rates, which are expected to grow steadily over coming years. The data gathered from the evaluation system will continue to be used to highlight and implement improvements in the scheme.

Following a proposal from ACRRM to the Australian Government, the JFSS program was awarded additional funds for a suite of marketing and promotional items to increase branding opportunities for the scheme. This includes the production of a CD-ROM about the scheme, revised promotional flyers, and production and distribution of a range of promotional merchandise to the scheme's stakeholders.

ACRRM would like to thank all the stakeholders in the JFSS for their continued contribution and support during 2005-2006. We look forward to working with you again in 2006-2007.



Medical Rural Bonded Support

The Medical Rural Bonded Support Scheme (MRB Support) commenced as a pilot project in 2003. MRB Support provides a range of services for MRB scholars, including providing:

- Networking, information and support;
- Access to a network of medical contacts; and
- A conference program that provides scholars with access to rural health oriented events.

The 2005 – 2006 year saw the successful completion of the pilot project and approval from the Department of Health and Ageing to implement the support program on an ongoing basis.

Participation in the scheme continued to grow during the period and as at 30 June 2006 stands at 458 scholars. This represents a wide range of participants from university students to doctors in their first and second post-graduate years. The virtual community and discussion groups also continued to develop, with 312 scholars participating over the year.

The MRB Support conference program offered stimulating education and networking opportunities for a large number of MRB scholars, across a variety of medical areas. During the period, ACRRM organised 196 scholar places to attend the following conferences:

- Provincial Surgeons of Australia Annual Scientific Conference, July 2005, Shepparton, VIC
- Mt Isa Centre for Rural and Remote Health: National Remote Health Conference, August 2005, Mt Isa, QLD
- 48th RACGP Annual Scientific Convention, Oct 2005, Darwin, NT
- Australian College of Rural and Remote Medicine and Rural Doctor's Association of Australia National Meeting, Oct 2005, Melbourne, VIC
- 10th National Prevocational Medical Education Forum, Nov 2005, Perth, WA
- Inaugural Toxinology Weekend, Dec 2005, Twin Waters, QLD
- Abrolhos Conference, March 2006, Abrolhos Islands, WA
- RANZCOG Rural Fellows Meetings, April 2006, Coffs Harbour, NSW
- ACRRM Workshop – 2nd Orientation to Rural and Remote Medicine, April 2006, Brisbane, QLD

The inclusion of meetings of the rural fellows of the Royal Australasian College of Surgeons and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists was a new feature of the conference program this year.

Work began during the period towards the future development of a mentoring and support program to assist scholars and those in their first and second postgraduate years.

ACRRM would like to thank all those stakeholders, including scholars, mentors and the MRB Management Committee that worked with us throughout the pilot project and made it a success. We look forward to working with you in the future to continue to develop this program.

I Training for Rural & Remote Procedural GPs Program



The Training for Rural and Remote Procedural GPs Program was an initiative of the Australian Government to provide financial support to medical practitioners that found it difficult to leave their community to undertake education and training activities. The program is therefore ideally suited to rural practitioners and has continued to grow in popularity throughout the financial year.

During the year the program was expanded into two components. The first component is for generalist practitioners in RRMA 3-7 that performed procedural medicine in areas such as surgery, obstetrics, and anaesthetics. The second component, for practitioners that undertake work in emergency medicine in RRMA 4-7, was introduced at the start of 2006 as a result of negotiations and advice provided to the Australian Government by ACRRM in collaboration with the RDAA and the RACGP.

Procedural

As at 30 June 2006, the total number of doctors registered with ACRRM for the procedural component of the program was 569. Doctors registered their specific disciplines of practice for the program in a variety of areas, including Anaesthetics (334), Obstetrics (418), and Surgery (189). Of these, 82 practitioners stated practice activity in all three areas.

A total of 1,686 claims to the value of \$6,405,500 were submitted to ACRRM during the period. These were then passed on to Medicare Australia who administers the funding. Training grant program and ACRRM PDP staff provided access to an extensive list of suitable training activities via ACRRM's RRMEO website, which was made available to all registered proceduralists (including non ACRRM members) along with instructions on how to search the site for suitable educational opportunities.

Activities also included accredited clinical attachment placements of which 186 posts were offered under this component of the program as opportunities for procedural upskilling.

Emergency Medicine

One of the most positive outcomes of the program's success to date was the announcement by the Minister for Health and Ageing that the program would expand to include emergency medicine, a field critical for procedural rural medical practitioners. While the emergency medicine component had only been operating for six months, by 30 June 2006 ACRRM had already registered 212 doctors, and received 84 claims to a value of \$175,500.

Outcomes Evaluation

ACRRM conducted an Outcomes Evaluation Report on the program in December 2005, which showed that the program had a positive impact on rural and remote procedural GP respondents in terms of:

- Their interests in maintaining and enhancing procedural skills; and
- Their intentions to remain in rural and remote practice.

With the program's core aim to deliver better access to an improved level of healthcare in rural and remote Australia, this research report provided great evidence that the program had made a positive step in keeping more proceduralist doctors in rural Australia.



I Rural & Remote Medical Education Online

Launching the new RRMEO

One of the major achievements for ACRRM during the period was the relaunch of the Rural and Remote Medical Education Online (RRMEO) web site. The new RRMEO was launched on Friday 9 June 2006 to coincide with presentation at the Rural Doctors Association of Queensland conference in Chinchilla, western Queensland.

The new RRMEO was designed, planned and rebuilt over a two year period, with extensive research and development undertaken to incorporate a far simpler and more user friendly interface, better design principals, and enhanced functionality. The new system was especially refined to make processes easier and more intuitive for visitors to the site, from locating members' items in their educational inventory, to accessing and enrolling in RRMEO online modules, and for record keeping and reporting in online learning planners.

Feedback and evaluation on the site showed immediate and overwhelmingly positive support from users and stakeholder groups.

Data input and reporting features were also greatly improved for RRMEO. For ACRRM Professional Development Program staff, the upgraded system provides an important role in maintaining PDP activity information and for maintaining records for members with third party obligations, such as meeting PDP requirements for other colleges, or for hospital credentialing.

Most importantly, during the 12 month period to 30 June 2006, RRMEO usage had grown to the following levels:

- 5041 active users
- Average of 610 unique users per month
- 11,561 visits recorded
- 824,414 hits recorded

Tele-Derm

One of the most successful individual programs conducted through RRMEO is Tele-Derm, which grew to total enrolments of nearly 900 during the period. Administered by leading Australian dermatologist Dr Jim Muir, Tele-Derm forums and case analyses remained popular and experienced further growth as an increasing number of doctors submitted cases for online advice and review.

For the period, Tele-Derm usage and online content had grown to the following levels:

- 868 enrolments
- 21,310 site hits recorded
- 282 online cases for users to work through
- More than 150 online consultations for the period were recorded

Tele-Derm and Radiology Online are joint initiatives with the Queensland Divisions of General Practice through funding from the Commonwealth Department of Health and Ageing.

Radiology Online

Radiology Online began in 2006 using the Tele-Derm model of online cases and the ability to consult with an online radiologist.

For the period, Radiology Online grew to the following levels:

- 320 enrolments
- 5,754 site hits recorded
- 41 online cases for users to work through
- Received 19 online consultations for the period

Supplementary Business

Other important new business involving RRMEO included winning a contract to publish 12 modules specifically for International Medical Graduates for the Royal Australian and New Zealand College of Psychiatrists (RANZCP). The project has been underway for most of 2006 with a launch expected in the latter half of the year. RANZCP also committed to an ongoing subscription to RRMEO to host their own modules, and discussions took place during the period for other cross college projects.

ACRRM also partnered with Palliative Care Australia to publish a moderated online module on RRMEO on the topic of 'Opioid use in Palliative Care'. The module went live in the second half of 2006 and will initially be moderated by two experts in palliative care.

PDA Clinical Guidelines

An important and ever expanding feature of ACRRM's education program is the clinical guidelines program for PDA and computer. The clinical guidelines for PDA provide portable, point of care clinical referencing to help with immediate patient management, and are uploaded and maintained via RRMEO.

A wide variety of guidelines that align with ACRRM curriculum syllabus topics have previously been produced, but many were updated and relaunched in May 2006. Total areas covered by the guidelines now include: Anaesthetics Crisis Algorithms (new in 2006), Anaesthetics, Adult Internal Medicine, Child and Adolescent Health, Dermatology, Emergency Medicine, Obstetrics and Women's Health, Ophthalmology, and Palliative Care.

New Staff

During the period a dedicated web publisher was employed. This role incorporates ongoing development and design of RRMEO and its individual programs, as well as developing and implementing cross College projects.

With the upgraded RRMEO and new and expanded online education and support modules, ACRRM has once again shown its leadership in the field of medical distance education, learning and support.



I Research and Evaluation

Launching the new RRMEO

ACRRM's research and evaluation team continued to provide a comprehensive range of internal evaluation services for each of ACRRM's program areas during 2005-2006. Research and evaluation is a vital element for each program and is designed to demonstrate program outcomes against targets set within each grant.

During the period, the team provided design and technical input to a number of evaluation projects within the John Flynn Scholarship Scheme (JFSS) and the Medical Rural Bonded Support Scheme (MRB Support). Evaluations were received from each stakeholder group, including scholars, mentors and community representatives to determine the satisfaction with each program and to become aware of any issues or potential opportunities.

This research provided advice on refinements to program activity as well as presenting objective outcomes testing for reporting to funding bodies.

Additionally, ACRRM was awarded the responsibility to conduct a separate outcomes and tracking project for both JFSS and the Prevocational General Practice Placements Program (PGPPP). The JFSS project aims to determine whether the placement experiences of John Flynn scholars had influenced their training and career choices in favour of rural and remote practice. Investigations for this project started during the period and will continue till June 2007.

PDP membership audit

As part of its quality assurance processes, an annual 10% random audit was conducted of ACRRM's Professional Development Program (PDP) membership. The audit ensured that ACRRM held current and accurate records for those members enrolled in PDP and that these were evidenced by sound recording processes and relevant and adequate documentation. The timing of the present audit, one year into the 2005-2007 Triennium, also provided an opportunity to review current PDP procedures and protocols to ensure that the PDP could continue to be refined and improved.

Research and evaluation staff also provided technical support to external evaluators working with the college during the period.

Publications

In the second half of 2005, ACRRM published the results of two external projects funded through the Office for Women, on the Continuing Professional Development Preferences of Women Doctors and National Guidelines for the Mentorship of Women Doctors in rural and remote practice. And as an outcome of the 2005 ACRRM/ RDAAA Symposium, the research team liaised with both organisations to publish a strategic outcomes report in September 2005 called Birthing Services in Small Rural Hospitals: sustaining rural and remote communities. Publications were then distributed to key stakeholders around Australia.

I Censor's Report



The 2006 year has been a period of change and opportunity for the College Censorial process. Other than a change of Censor, our progress towards Australian Medical Council (AMC) recognition of the Fellowship and anticipated vocational recognition in national Health Insurance Act regulations has significant implications for existing College standards, training and recognition arrangements. This has been a dominant theme in the Censorial process, particularly during the latter part of the year.

The existing vocational pathways to Fellowship pose few challenges. Straight forward transition arrangements will be in place for current 'parallel pathway' and Remote Vocational Training Stream (RVTS) registrars. New entrants to vocational training will have the benefit of new flexible training opportunities under an ACRRM vocational training pathway that has a stand-alone VR endpoint.

It is the experience-based pathway to Fellowship (and the current independent training route) that will be most impacted by the changes. Over the 2006 financial year, there were 52 applicants for Fellowship under the Experience-based pathway, 30 of whom were awarded Fellowship. We are now advising Fellows of a likely requirement for a summative assessment as a condition of VR access and we will continue to work with Fellows and the Department of Health and Ageing on this and associated issues.

The implementation of the ACRRM summative assessment model will require a reconfiguration of the Censorial committees. This is under consideration through the ACRRM organisational review as well as the assessment consultancy.

The College's successful Professional Development Program has continued to evolve under the leadership of Dr Stephen Holmes, chair of the PDP subcommittee. Changes include the completion of the contract with the Department of Health and Ageing that had funded positions for state-based PDP staff. There has been enhanced activity in accreditation of professional development activities and continuing refinement of the guidelines for award of PDP points.

Other Censorial activities have included the accreditation of Regional Training Providers, practice accreditation, policy work with Australian General Practice Training, and other matters such as appraisal and endorsement of clinical practice guidelines.

What are the challenges ahead? Firstly, the roll-out of our programmatic assessment model will have significant implications for administration, delivery and evaluation standards within Censorial processes and require a revision of committee structures. A College code of professional practice is under development. Quality and safety in professional practice remains a critical health policy area for the College to be proactively engaged with. Our international linkages and leadership in the discipline of Rural and Remote Medicine provide opportunities for us to extend the Censorial process internationally, formalising our networks in countries like South Africa, Canada and the United States.

In short, there are exciting prospects for the College and for the future of Rural and Remote Medicine, a future that will continue to be underpinned by clear standards through an active Censorial process. I would like to thank all members of the Censor's committee and subcommittees as well as Andrena Doyle, Vicki Sheedy, Di Wyatt and the other College staff. Finally, I particularly acknowledge Associate Professor Dennis Pashen, my predecessor in the role of Censor, for his past and continuing commitment and contribution to College standards.

A/Prof Richard Murray
Censor

05-06

Australian College of
Rural and Remote Medicine

A.C.N 078 081 848

FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2006

I Directors' Report

The Directors submit the following report for the year ended 30 June 2006 made 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 David Campbell
 Associate Professor Dennis Pashen (appointed 29 October 2005)
 Dr Patrick Giddings
 Dr Stephen Holmes
 Dr Neil Beaton (appointed 29 October 2005)
 Dr Ruth Stewart
 Dr Ian Kamerman
 Dr John Togno (appointed 29 October 2005)
 Dr Megan Rathbone
 Dr Kris Bascomb (appointed 2 April 2006)
 Dr Peter Rischbieth (appointed 20 November 2005)
 Associate Professor Elizabeth Chalmers
 Dr Robert Seton
 Dr Louis Peachey
 Dr Alan Chater
 Dr Bruce Cameron (resigned 29 October 2005)
 Dr Elizabeth Dodd (resigned 29 October 2005)
 Dr Frederic McConnel (resigned 6 February 2006)
 Dr James McLennan (resigned 30 October 2005)
 Dr Timothy Wootton-Leeuwenburg (resigned 29 October 2005)

PRINCIPAL ACTIVITIES

The principal activity of the Company during the year ended 30 June 2006 was the provision of medical education and training services to doctors in rural and remote areas.

No significant changes in the nature of the above activity occurred during the year.

REVIEW AND RESULTS OF OPERATIONS

The surplus from ordinary activities for the year ended 30 June 2006 amounted to \$5,778,333 (2005: \$1,905,690). This surplus is made up of a College surplus of \$1,111,755 and a project surplus of \$4,666,578.

The project surplus of \$4,666,578 is a direct result of timing differences between the receipt of grant funding and expenditure of these funds and where these fall in relation to the end of financial year cutoff. Over the life of the projects budgets will be met without any deficits resulting.

DIVIDENDS AND OPTIONS

The company is limited by guarantee and consequently no dividends have been paid or options issued.

LIKELY FUTURE DEVELOPMENTS AND EXPECTED RESULTS

ACRRM anticipates a continuation in 2006/2007 of its positive performance and growth with a focus on providing high quality education and training services to rural and remote medical practitioners in Australia.

The College will complete the Australian Medical Council initial accreditation process and it is anticipated that this will enable ACRRM's programs to be fully implemented and recognised under Medicare as a generalist discipline.

It will expand its role in setting professional standards for Rural and Remote Medicine and work with key stakeholders to support relevant training that responds to the needs of practitioners and their communities.

SIGNIFICANT CHANGES IN STATE OF AFFAIRS

There were no significant changes in the state of affairs of the company during the year.

INFORMATION OF 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 David Campbell

MBBS, Dip RACOG, DCH, FRACGP, FACRRM

Dr David Campbell was elected President of ACRRM on 29 October 2005. Dr Campbell has been in rural practice in Lakes Entrance in Victoria for 24 years. Dr Campbell is currently the Director of East Gippsland Regional Clinical School, School of Rural Health, Monash University. He is a Board member of Gippsland Education and Training for General Practice and a Director and Board member of the Rural Workforce Agency, Victoria. Dr Campbell represents ACRRM on the Medical Training Review Panel (MTRP) and the Victorian Rural Procedural Services Advisory Group.

Associate Professor Dennis Pashen

MBBS (Qld), MPHTM, FRACGP, FACRRM

Associate Professor Dennis Pashen was elected Vice President of ACRRM on 29 October 2005 and is currently the Director of the Mt Isa Centre for Rural and Remote Health. Associate Professor Pashen has a background in rural practice, medical education and population health and has held a number of positions on statutory bodies.

Dr Patrick Giddings

MBBS, FACRRM, FRACGP, DRANZCOG, Grad. Dip. Fam. Med

Dr Pat Giddings was elected Treasurer of ACRRM on 29 October 2005 and is currently the Chief Executive Officer of Bogong Regional Training Network in Victoria and Southern New South Wales. Dr Giddings is also the Program Manager for the Remote Vocational Training Stream (RVTS). He is based in Albury-Wodonga.

Dr Stephen Holmes

MBBS (Adelaide), DRACOG, FRCPA, FACRRM

Dr Stephen Holmes is currently the South Australian Director on the ACRRM Board. Dr Holmes has worked in rural medicine for 16 years and has been in solo practice in Clare, South Australia and surrounding regions since 1996. Dr Holmes chairs ACRRM's Professional Development Committee and represents the college on the Quality Use of Pathology Committee.

Dr Neil Beaton

MBBS, MRCGP, DA, FACRRM

Dr Neil Beaton was elected Queensland Director on the ACRRM Board on 29 October 2005. Dr Beaton is the Medical Superintendent at Atherton Hospital and Senior Lecturer General Practice and Rural Medicine, James Cook University School of Medicine. Dr Beaton was appointed in November 2005 as ACRRM's representative on the Queensland Health, Ministerial Taskforce to develop procedures for ensuring Medical Practitioner Competency and Recruitment.

Dr Ruth Stewart

MBBS, DRANZCOG, FACRRM

Dr Ruth Stewart is currently the Women in Rural Practice (WIRP) Director on the ACRRM Board and the college's representative on the Victorian Metropolitan Alliance (VMA) Board. Dr Stewart represents ACRRM on a number of external committees including the National Evidence Based Antenatal Guideline Project Review Panel and the Department of Human Services, Victoria, Credentialing Advisory Group.

Dr Ian Kamerman

MBBS (Syd), DRANZCOG, DA (UK), Dip CD, SFCDA, FACRRM

Dr Ian Kamerman is currently the New South Wales Director on the ACRRM Board and ACRRM's representative on the Board of New England Area Training Services (NEATS). Dr Kamerman represents ACRRM on a number of external committees including the New South Wales GP Unity Group and the Royal Australasian College of Physicians, Palliative Care Joint Steering Committee. Currently he is principal of Northwest Health, which provides rural medical services in Bingara and Tamworth in New South Wales.

Dr John Togno

MBBS, FACRRM

Dr John Togno was elected Victorian Director on the ACRRM Board on 29 October 2005. Dr Togno is currently the Chief Executive Officer and Senior Medical Educator for Victoria Felix Medical Education (VFME). In his combined role, Dr Togno takes on significant responsibility for the design, administration and delivery of the AGPT for trainees in the VFME region.

Dr Megan Rathbone

MBBS, FACRRM

Dr Megan Rathbone is currently the Tasmanian Director on the ACRRM and ACRRM's representative on the Board of General Practice Training Tasmania. Dr Rathbone is an Associate at the Wynyard Doctors Surgery in Burnie Tasmania.

Dr Kris Bascomb

MBBS

Dr Kris Bascomb was appointed Registrar Director on the ACRRM Board on 2 April 2006. Dr Bascomb is currently a rural registrar with Adelaide to Outback, and with a strong interest and experience in surgery and O&G.

Dr Peter Rischbieth

MBBS, DObs, RACOG, DAAnaes (Lond)

Dr Peter Rischbieth is currently the Rural Doctors Association of Australia (RDAA) representative on the ACRRM Board. Dr Rischbieth is the Vice President (Education), RDAA and currently the President of RDA South Australia. Dr Rischbieth has been in rural practice for 19 years in Murray Bridge, South Australia with interests including Anaesthetics, Obstetrics and Hospital Administration.

Associate Professor Elizabeth Chalmers

MBChB, MPH, FAFPHM, FACHAM, FACRRM

Associate Professor Elizabeth Chalmers is currently the Academic Director on the ACRRM Board and the college's representative on the Northern Territory General Practice Education. Associate Professor Chalmers represents ACRRM on a number of external committees including the Editorial Board of the Australian Journal of Rural Health (AJRH) and the National Primary Care Collaborative Clinical Stakeholder Group.

Dr Robert Seton

MBChB, FRACGP, FACRRM

Dr Robert Seton is currently the Western Australian Director on the ACRRM Board. Dr Seton is based in Narrogin, South East Western Australia. Dr Seton has a strong background in rural general practice with strong procedural experience, particularly in the areas of Gynaecological and Obstetric work.

Dr Louis Peachey

B.Med (University of Newcastle upon Hunter), FACRRM

Dr Louis Peachey is currently the Chair, Chapter of Indigenous Health on the ACRRM Board and Medical Educator at the Mount Isa Centre for Rural and Remote Health (MICRRH), James Cook University. Dr Peachey is ACRRM's representative on the Joint Organising Committee for a National workshop in primary health care in Aboriginal and Torres Strait Islander communities.

Dr Bruce (Alan) Chater

MBBS Hons (Qld), DRANZCOG (Advanced), FRACGP, FACRRM

Dr Bruce Chater is the Immediate Past President of ACRRM and Associate Professor and Head of the Discipline, Rural and Remote Medicine and Chair, Clinical School Management Committee, Rural Clinical School, University of Queensland. Dr Chater has more than 20 years experience as a solo procedural practitioner in small community of Theodore in Central Queensland. Dr Chater is currently the Australian delegate to the WONCA International Rural Working Party.

Dr Bruce Cameron

BSc Hons (Geophysics), DRANZCOG, FACRRM

Dr Bruce Cameron was previously the Queensland Director on the ACRRM Board. Dr Cameron is in part time rural practice in North Queensland. Dr Cameron previously held positions as President of the Rural Doctors Association of Queensland (RDAQ) and Vice President (Education) of RDAA.

Dr Elizabeth Dodd

MBBS (Syd), FRACGP, FACRRM

Dr Elizabeth Dodd was previously the College Treasurer and is in full time rural practice in Griffith, New South Wales. Dr Dodd is currently ACRRM's representative on the National Chlamydia Program Implementation Committee and National Rural Health Alliance (NRHA).

Dr Frederic McConnel

MBBS (UQ), Dip RACOG, FAFPHM, MHP, FACRRM

Dr Frederic McConnel was previously the Northern Territory Director on the ACRRM Board and is currently a part time rural medical practitioner working in Aboriginal Communities in the Northern Territory. Dr McConnel was Medical Workforce Advisor to Northern Territory Department of Health and Community Services and has worked in rural and remote regions of Australia for more than 30 years.

Dr James McLennan

MBBS, Dip RACOG, Dip FCA, FACRRM

Dr James McLennan was previously the Rural Doctors Association of Australia (RDAA) representative on the ACRRM Board and is currently the South Australian representative on the Committee of Management, RDAA. Dr McLennan is in full time rural practice in Clare, South Australia.

Dr Timothy Wootton-Leeuwenburg

MBBS

Dr Timothy Wootton-Leeuwenburg was previously Registrar Director on the ACRRM Board and is currently based at Kangaroo Island, South Australia.

Ms Marita Cowie

BA (Psych), BBus (Com), MEd (T&D)

Marita Cowie was appointed Company Secretary of the College in 1998. She is also the foundation Chief Executive Officer of ACRRM. Marita has more than 12 years experience in medical education, training and company administration. She is also a Director on the Board of Genex Pty Ltd and Company Secretary of MMB Investments.

MEETINGS OF DIRECTORS

During the 2005-2006 financial year, meetings of directors were held, with attendance as follows:

DIRECTORS	Directors Meetings	
	<i>Eligible to attend</i>	<i>Attended</i>
Dr David Campbell	12	11
Associate Professor Dennis Pashen	8	7
Dr Patrick Giddings	8	8
Dr Stephen Holmes	12	12
Dr Neil Beaton	8	5
Dr Ruth Stewart	12	10
Dr Ian Kamerman	12	8
Dr John Togno	8	5
Dr Megan Rathbone	12	11
Dr Kris Bascomb	3	3
Dr Peter Rischbieth	7	6
Associate Professor Elizabeth Chalmers	12	7
Dr Robert Seton	12	9
Dr Louis Peachey	12	9
Dr Alan Chater	4	4
Dr Bruce Cameron	4	3
Dr Elizabeth Dodd	4	4
Dr Frederic McConnel	8	8
Dr James McLennan	5	4
Dr Timothy Wootton-Leeuwenburg	4	0

ATTENDANCE OF EX OFFICIO BOARD MEMBERS AT THE MEETING OF DIRECTORS

EX OFFICIO MEMBERS	Directors Meetings	
	<i>Eligible to attend</i>	<i>Attended</i>
Professor Ian Wronski, Immediate Past President	4	3
Dr Tom Doolan, Hon. Director of Education	12	8
Associate Professor Dennis Pashen, Censor	4	3
Dr Alan Chater, Immediate Past President	8	8
Associate Professor Richard Murray, Censor	4	4
Ms Marita Cowie, Chief Executive Officer	12	12

There is one formally constituted committee of the Board being the Executive Committee. During the financial year, 6 meetings of the Executive Committee were held, with attendance as follows:

EXECUTIVE MEMBERS	Executive Meetings	
	<i>Eligible to Attend</i>	<i>Attended</i>
Dr David Campbell, President	6	6
Associate Professor Dennis Pashen, Vice President	6	6
Dr Patrick Giddings, Treasurer	6	5
Dr Ruth Stewart, Women in Rural Practice Director	6	5
Ms Marita Cowie, Chief Executive Officer	6	6

The Finance Committee (previously Audit Committee) during the financial year had 3 meetings, with attendance as follows:

FINANCE COMMITTEE MEMBERS

FINANCE COMMITTEE MEETINGS

	<i>Eligible to attend</i>	<i>Attended</i>
Dr Elizabeth Dodd, Treasurer, Chair	1	1
Dr Patrick Giddings, Treasurer, Chair	2	2
Dr Alan Chater, President	1	1
Dr David Campbell, Vice President	1	1
Dr Ruth Stewart (Executive Member)	3	3
Dr Stephen Holmes (Non-executive Member)	3	3
Dr Ian Kamerman (Non-executive Member)	2	0
Ms Marita Cowie, Chief Executive Officer (Ex-Officio Member)	3	3

SIGNIFICANT AFTER BALANCE DATE EVENTS

No matters or circumstances have arisen after the end of the financial year that have significantly affected or may significantly affect the operations of the company, the results of those operations, or the state of affairs of the company, in subsequent financial years.

ENVIRONMENTAL REGULATIONS

There has been no matter, either during or since the end of the financial year, which in the opinion of the directors, would give rise to any conflict with the provisions of existing environmental regulation.

INDEMNIFICATION OF OFFICERS

During or since the financial year the company has paid premiums to insure each of the directors and officers against liabilities for the costs and expenses incurred by them in defending any legal proceedings arising from a wrongful act while acting in their capacity of officer of the company. The policy prevents the company from disclosing premiums paid.

PROCEEDINGS ON BEHALF OF THE COMPANY

No proceedings have been entered into on behalf of the company.

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

Director



Dated at this 5th day of October, 2006.

AUDITOR'S INDEPENDENCE DECLARATION UNDER SECTION 307C OF THE CORPORATIONS ACT 2001 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 2006 there have been:

- (i) no contraventions of the auditor independence requirements as set out in the Corporations Act 2001 in relation to the audit; and
- (ii) no contraventions of any applicable code of professional conduct in relation to the audit.



BENTLEYS MRI
Brisbane Partnership
Chartered Accountants



R J Forbes
Dated at Brisbane this 5th day of October 2006

DIRECTORS' DECLARATION

In the opinion of the Directors of the Australian College of Rural and Remote Medicine Limited:

- (a) the accompanying financial statements and notes are in accordance with the Corporations Act 2001, comply with the accounting standards and give a true and fair view of the company's financial position as at 30 June 2006 and its performance for the year ended on that date.
- (b) at the date of this declaration 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.

Director



Dated at this 5th day of October, 2006.

INCOME STATEMENT FOR THE YEAR ENDED 30 JUNE 2006

	Notes	2006 \$	2005 \$
Revenues from Ordinary Activities	2	16,012,806	9,343,627
Expenses from Ordinary Activities	3	(10,234,473)	(7,427,937)
Surplus/(Deficit) from Ordinary Activities		5,778,333	1,915,690
Income Tax Expense		-	-
Net Surplus/(Deficit)		5,778,333	1,915,690

*The above Income Statement should be read in conjunction with the attached notes

BALANCE SHEET AS AT 30 JUNE 2006

	Notes	2006 \$	2005 \$
CURRENT ASSETS			
Cash and Cash Equivalents	5	11,797,955	7,158,671
Trade and Other Receivables	6	3,778,046	1,514,546
Other Assets	7	88,095	354,308
TOTAL CURRENT ASSETS		15,644,096	9,027,525
NON-CURRENT ASSETS			
Intangible Assets	8	197,318	-
Plant and Equipment	9	133,514	170,794
TOTAL NON-CURRENT ASSETS		330,832	170,794
TOTAL ASSETS		15,994,928	9,198,319
CURRENT LIABILITIES			
Trade and Other Payables	10	2,025,218	1,192,075
Short-term Provisions	11	136,958	90,900
TOTAL CURRENT LIABILITIES		2,162,176	1,282,975
NON-CURRENT LIABILITIES			
Long-term Provisions	11	160,620	21,545
TOTAL NON-CURRENT LIABILITIES		160,620	21,545
TOTAL LIABILITIES		2,322,796	1,304,520
NET ASSETS		13,672,132	7,893,799
EQUITY			
Retained Earnings	12	13,672,132	7,893,799
TOTAL EQUITY		13,672,132	7,893,799

*The above Balance Sheet should be read in conjunction with the attached notes

CASH FLOW STATEMENT AS AT 30 JUNE 2006

	Notes	2006 \$	2005 \$
Cash Flows from Operating Activities			
Receipts from Members		1,934,611	1,087,928
Interest Received		548,747	312,714
Grants Received		11,581,210	7,619,582
Payments to Suppliers and Employees		(8,224,166)	(6,832,999)
GST Recovered/(Paid)		(982,958)	(511,647)
Net Cash from Operating Activities	20(i)	<u>4,857,444</u>	<u>1,675,578</u>
Cash Flows from Investing Activities			
Payments for Intangibles		(201,364)	-
Payments for Property, Plant and Equipment		(16,796)	(56,742)
Net Cash Used in Investing Activities		<u>(218,160)</u>	<u>(56,742)</u>
Net Increase in Cash held		4,639,284	1,618,836
Cash at the Beginning of the Financial Year		7,158,671	5,539,835
Cash at the End of the Financial Year	20(ii)	<u>11,797,955</u>	<u>7,158,671</u>

*The above Cash Flow Statement should be read in conjunction with the attached notes

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

1. SUMMARY OF ACCOUNTING POLICIES

These financial statements constitute a general purpose financial report which have been drawn up in accordance with Accounting Standards, other authoritative pronouncements of the Australian Accounting Standards Boards, Urgent Issues Group Consensus Views and the Corporations Act 2001.

The financial report of Australian College of Rural and Remote Medicine Limited ("the College") complies with all Australian equivalents to International Financial Reporting Standards (AeIFRS) in their entirety.

First-time Adoption of Australian Equivalents to International Financial Reporting Standards

The College has prepared financial statements in accordance with the Australian equivalents to International Financial Reporting Standards (AeIFRS) from 1 July 2005. However, no adjustments were identified on transition to AeIFRS.

Basis of Preparation

The statements 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 noncurrent assets and their impact on operating results.

Income Tax

The entity 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.

Depreciation is calculated on the Diminishing Value Method so as to write the assets off over their estimated useful lives. The average depreciation rate for office equipment ranges between 20 and 40%. New assets are depreciated from the date of commissioning.

Revenue Recognition

- (a) Grants received are brought to account as revenue where:
- The company has control over the contribution;
 - It is probable that the economic benefit comprising the contribution will flow to the company; and
 - The amount of the contribution can be reliably measured.
- (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.

Concentration of Credit Risk

The Company has one significant concentration of credit risk being the Department of Health and Ageing amounting to \$3,728,599. This is equivalent to 98.69% of the total debtors balance.

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.

Intangible Assets

The cost of creating a website has been capitalised under the conditions set out in UIG37. The expense is being amortised over a period of three years and any further expenses incurred for maintenance will be expensed to the Income Statement.

Credit Risk Exposure

Credit risk represents the risk of counterparty default. The maximum credit risk exposure is represented by the carrying amount of assets in the statement of financial position net of any provisions for losses.

Receivables

Trade receivables represent the principal amounts outstanding at balance date, are non interest bearing and are usually settled within 30 days.

Payables

Payables represent the principal amounts outstanding at balance date, are non interest bearing and are usually settled within 30 days.

Net Fair Value

The net fair value of all financial assets and liabilities are represented by their book value unless otherwise stated.

2. REVENUES FROM ORDINARY ACTIVITIES

	2006 \$	2005 \$
Operating Revenue		
Rendering of Services	1,543,645	1,079,082
Grant Income	13,899,394	7,903,488
Sponsorship	18,000	9,731
Sundry Income	3,020	38,612
Non Operating Revenue		
Interest	548,747	312,714
	16,012,806	9,343,627

3. EXPENSES FROM ORDINARY ACTIVITIES

	2006	2005
	\$	\$
<i>Classification of Expenses by Function:</i>		
College Services & Admin Expenses	959,784	956,864
Publication & Communication Services	41,873	47,313
RRAPP Grant Expenses	-	913,450
Radiology Grant Expenses	-	31,971
Professional Development Program Grant Expenses	1,618,254	1,250,199
John Flynn Scholarship Scheme Grant Expenses	2,460,393	1,665,599
Obstetric Ultrasound Grant Expenses	127,773	159,704
Medical Rural Bonded Scholarship Grant Expenses	517,512	476,864
GP Procedural Grant Expenses	168,119	92,411
OTD Supervisors Grant Expenses	41	-
SEAC Grant Expenses	143,130	-
PGPPP Grant Expenses	4,197,594	1,833,562
	<u>10,234,473</u>	<u>7,427,937</u>
<i>Other Expenses:</i>		
Employee Benefits Expense	282,283	150,774
Amortisation and Depreciation Expense	57,187	140,068

4. SURPLUS/(DEFICIT) FROM ORDINARY ACTIVITIES

<i>Surplus/(Deficit) from Ordinary Activities includes:</i>		
Net (Gain)/Loss from sale of Plant and Equipment	934	5,225
Net Expense resulting in movements in provisions:		
Depreciation	53,142	57,035
Amortisation	4,045	83,033

5. CASH AND CASH EQUIVALENTS

Cash on Hand	100	100
Cash at Bank	4,255,321	903,119
Cash on Deposit	7,542,534	6,255,452
	<u>11,797,955</u>	<u>7,158,671</u>

6. TRADE AND OTHER RECEIVABLES

Trade Receivable	3,778,046	1,514,546
	<u>3,778,046</u>	<u>1,514,546</u>

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

Directors (other than loans to directors)	-	108
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7. OTHER ASSETS

Prepayments	88,095	132,485
Accrued Income	-	221,823
	<u>88,095</u>	<u>354,308</u>

8. INTANGIBLE ASSETS

Website Development	699,363	498,000
Accumulated Amortisation	(502,045)	(498,000)
	<u>197,318</u>	<u>-</u>

9. PLANT AND EQUIPMENT

	2006 \$	2005 \$
Office Equipment	321,731	314,637
Accumulated Depreciation	(188,217)	(143,843)
	133,514	170,794
Movement Schedule		
Opening Balance	170,794	176,253
Additions	16,796	56,742
Disposals at Written Down Value	(934)	(5,166)
Depreciation Expense	(53,142)	(57,035)
Closing Balance	133,514	170,794

10. TRADE AND OTHER PAYABLES

(i) Current		
Trade and Sundry Creditors	820,735	214,810
Unearned Income	773,105	679,665
Accruals	221,431	219,447
GST Payable	342,947	78,153
	2,025,218	1,192,075

Included in unearned income, are amounts from directors:

8,091	4,000

11. PROVISIONS

(i) Current		
Employee Benefits	103,958	90,900
Provision for "Make Good"	33,000	20,000
	136,958	110,900

(ii) Non-Current		
Employee Benefits	60,620	21,545
Provision for "Make Good"	100,000	-
	160,620	21,545

Aggregate liability arising from employee benefits:

Short-Term Provisions		
Provision for Annual Leave	103,958	90,900
Employee Benefit Accruals	31,205	21,766
	135,163	112,666
Long Term Provisions		
Provision for Long Service Leave	60,620	21,545
	195,783	134,211

12. RETAINED SURPLUS

Retained Earnings at the beginning of year	7,893,799	5,978,109
Net Surplus/(Deficit)	5,778,333	1,915,690
Retained Earnings at the end of year	13,672,132	7,893,799

*Note 12 replaces the Statement of Changes in Equity.

13. AUDITORS REMUNERATION

	2005 \$	2004 \$
Audit and review of Financial Statements	5,000	5,000
Other Project Audit Services	6,000	5,000
	11,000	10,000
	11,000	10,000

14. COMMITMENTS FOR EXPENDITURE

Non-cancellable operating lease for lease of premises		
Commitments not provided for:		
No later than 1 year	80,770	80,770
Later than 1 year but no later than 5 years	-	80,770
	80,770	161,540
Licence fee for intellectual property (RRMEO)		
Commitments not provided for:		
No later than 1 year	15,000	-
Later than 1 year but no later than 5 years	135,000	-
	150,000	-
	230,770	161,540

15. MEMBERS 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.

16. 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 to rural and remote areas. The principal place of business and registered office of the Australian College of Rural and Remote Medicine Limited is Level 4, 410 Queen Street, Brisbane, Queensland. There are 35 employees (2005: 28) at the end of the reporting period.

17. SEGMENT INFORMATION

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

18. 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 and Ageing.

19. RELATED PARTY TRANSACTIONS

The directors of the company pay membership fees under normal terms and conditions. They are not remunerated by the company. The names of persons who held office during the year are as follows:

2006

Dr David Campbell
 A/ Professor Dennis Pashen (appointed 29/10/05)
 Dr Patrick Giddings
 Dr Stephen Holmes
 Dr Neil Beaton (appointed 29/10/05)
 Dr Ruth Stewart
 Dr Ian Kamerman
 Dr John Togno (appointed 29/10/05)
 Dr Megan Rathbone
 Dr Kris Bascomb (appointed 2/04/06)
 Dr Peter Rischbieth (appointed 20/11/05)
 A/Professor Elizabeth Chalmers
 Dr Robert Seton
 Dr Louis Peachey
 Dr Alan Chater
 Dr Bruce Cameron (resigned 29/10/05)
 Dr Elizabeth Dodd (resigned 29/10/05)
 Dr Frederic McConnel (resigned 6/02/06)
 Dr James McLennan (resigned 30/10/05)
 Dr Timothy Wootton-Leeuwenburg
 (resigned 29/10/05)

2005

Dr Alan Bruce Chater
 Dr David Campbell
 Dr Elizabeth Dodd
 Dr Stephen Holmes
 Dr Bruce Cameron
 Dr Ruth Stewart
 Professor John Murdoch (resigned 20/11/04)
 Dr Ian Kamerman
 Dr Fred McConnel
 Associate Professor Elizabeth Chalmers
 Dr Pat Giddings
 Dr Myrle Gray (resigned 20/11/04)
 Dr John Heinrich (resigned 20/11/04)
 Dr Robert Seton (appointed 20/11/04)
 Dr Megan Rathbone (appointed 20/11/04)
 Dr James McLennan (appointed 21/11/04)
 Dr Louis Peachey (appointed 21/11/04)
 Dr Timothy Wootton-Leeuwenburg
 (appointed 20/11/04)

20. NOTES TO THE CASH FLOW STATEMENT

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

	2006	2005
	\$	\$
Surplus/(Deficit) from ordinary activities after income tax	5,778,333	1,915,690
Depreciation	53,142	57,035
Amortisation	4,045	83,033
Loss/(Gain) on Disposal of Assets	934	5,225
(Increase)/Decrease in Trade Debtors	(2,263,500)	(3,034,426)
(Increase)/Decrease in Non-Trade Debtors	-	-
(Increase)/Decrease in Prepayments	266,213	(318,105)
Increase/(Decrease) in Unearned Income	93,440	201,845
Increase in Trade Creditors and Accruals	607,123	2,759,058
Increase in Provisions	52,133	30,851
GST Clearing	265,581	(24,628)
Net Cash Provided by Operating Activities	<u>4,857,444</u>	<u>1,675,578</u>

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

ii) Reconciliation of Cash

Cash on Hand	100	100
Cash at Bank	4,255,321	903,229
Cash on Deposit	7,542,534	6,255,452
	<u>11,797,955</u>	<u>7,158,681</u>

iii) Cash

Cash balances and short-term deposits are stated at their principal amounts are held at call, subject to fixed and variable interest rates. Interest is recognized when earned.

21. EVENTS AFTER THE BALANCE SHEET DATE

- a) No significant events have occurred since the year end.
- b) The financial report was authorised for issue on 3rd October 2006 by the board of directors.

22. FINANCIAL INSTRUMENTS**Credit Standby Facilities**

The company had no credit standby facilities as at 30 June 2006.

Unused/Used Financing Facilities


The company had no financing facility as at 30 June 2006.

Interest Rate Expense

The company does not engage in any transactions which are speculative in nature. Financial assets and liabilities other than cash disclosed in financial statements are noninterest bearing in nature.

05-06





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