

australian college of rural and remote medicine

acrmm



Annual Report 2002 - 2003

Honouring the past and securing the future of Rural and Remote Medicine

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The Establishment of the Australian College of Rural & Remote Medicine

In 1996, the Rural Doctors Association of Australia conducted a national plebiscite of rural doctors and rural registrars throughout Australia to assess the type of organisational structure they felt would best represent the aspirations and needs of their profession.

Rural doctors voted to establish a separate college by a compelling margin of 2:1. Following the plebiscite the state rural doctors associations established a series of working parties to formulate the constitutional, policy and operational parameters for the new college. This work was documented in the foundation prospectus for the Australian College of Rural and Remote Medicine (ACRRM).

ACRRM was incorporated in March 1997 with 600 foundation members. Since that time the College has grown in reputation and size and leads the world in defining and supporting the specialty of rural and remote medicine.

PRESIDENT'S REPORT



During the latter half of the 2002-2003 financial year some of the most rewarding events in ACRRM's history took place. Those events will come to be seen as a major watershed that changed the nature of ACRRM's development and gave tangible recognition to the work of my predecessors and the college's pioneers.

The Federal Government had long ago promised to formalise ACRRM's role in providing professional development for rural medical practitioners but, as all rural communities are aware, there is often a large gap between the rhetoric and reality. Without ongoing vigilance and encouragement, political commitments can dissipate. Fortunately, mid way through the financial year the Federal Minister for Health and Ageing, Senator Kay Patterson acted on the standing commitment and initiated dialogue between ACRRM and the Royal Australian College of General Practitioners. The ACRRM professional development program is now formally accepted in its own right for maintenance of Vocational Recognition (VR).

The Government actions that resulted in recognition of ACRRM's professional development role are part of a broader philosophical recognition that ACRRM has become a reality on the college landscape. These specific actions crystallised the de facto reality, and probably the de jure reality, that ACRRM offers a fellowship-training program. That was a very important thing to achieve in what is still ACRRM's early development. ACRRM is delivering and is a reality. It's meaning, importance, values and reality have all crystallised.

ACRRM's professional development program is a quality program that addresses access difficulties through a web-based platform and by creative use of satellite broadcasts and other communications technology. It is also typified by streamlined administrative procedures that reduce the "red tape" burden. I expect that over time ACRRM's technological solutions, processes and administrative procedures will be adapted by other organisations as they respond to the need to provide quality professional development for other health professionals in rural and remote settings.

Our work in professional development is being paralleled by quality innovation in curriculum, standards and vocational training. The world is no longer focused on how best to view the ACRRM phenomenon but on how best to learn from ACRRM's quality programs and services.



"We must be prepared to strongly pursue our legitimate goals in an increasingly politicised environment where commonsense does not always prevail."



A number of countries are also monitoring intensely as ACRRM goes through the AMC process. The AMC process is exceptionally important for rural medicine because it will ensure further credibility and will open up new "legal opportunities". The "official" recognition of rural medicine as a specialty will be an international first and will cement Australia's position as leading the world in this area.

The ramifications of AMC recognition of rural medicine will be quite significant. There will be a cascade of administrative, remunerative and legal benefits for those clambering to get into rural medicine and those already in rural medicine. It will have profound consequences for the development and retention of the rural workforce, especially in the Australian context where it is intrinsically linked to remuneration schemes. Ultimately, it should lead to the creation of relevant Medicare item numbers that will operate at different levels to recognise the complexities and underpinning skills of various procedures and processes within a rural setting.

Recognition and promotion of the concept of rural medicine is not just an Australian phenomenon. It arises from a contemporary concern in many countries, developed and developing, about how we are going to service rural areas. Ultimately, its genesis comes from workforce and infrastructure shortages and consideration of the training programs and structures that are required to sustain rural medical services. Recognition of a separate discipline reflects the large gap between metropolitan general practice and rural medicine and the fact that the gap is widening. Recognition of a separate discipline also reflects developments in other countries that, in effect, constitute different approaches to recruitment and training of medical students destined for rural medicine. These initiatives have been in operation for a number of years in the USA and Canada.

Progress in Australia toward official recognition of a separate discipline is ahead of the rest of the world but was delayed by historical events. In the past, practitioners of rural medicine put their trust in the Royal Australian College of General Practitioners but it failed to deliver. This resulted in rural practitioners recognising the fact that they were better off on their own and their decision to form their own college. From that point in time, the only impediments to progress were political.

When ACRRM makes its formal AMC submission next year, it will be a landmark document. It will reflect the maturity of the philosophical analysis that sustains the new discipline. It will also reflect the intellectual rigour of the work done by ACRRM in recent years regarding understanding rural medicine and defining it.

The over-riding reason that our college is now at the leading edge of developments in rural medicine is that it has "a fantastic brains trust" among its membership and, just as importantly, a huge depth of talent, skills and intellectual capacity amongst staff. Throughout our fledgling college we have a huge



reservoir of innovation. Throughout layers of our membership there are exceptional qualities that have been honed as we have fought for our destiny against self-interested opponents. We are now tapping into those qualities as we forge ahead with new programs. In terms of conceptualisation and pedagogy we are right out in front.

In the years ahead, as the national commitment to the health budget increases, there will be ongoing pressure on credentialing and certification of medical practitioners. This will arise from review of data about error rates and an expectation that practitioners should perform better. The different branches of the medical profession will have to consider how they will respond to these pressures. This will evolve as a major problem but ACRRM will be well positioned. One of the advantages of being a new college is that you don't have a lot of "baggage". ACRRM will not be hampered by legacy systems. It will stay out in front, and provide value for its members, by continuing to be responsive and innovative. As a college we have the great strength of a culture that promotes constant rebirth and innovation and values new ideas.

The end of the 2002-2003 financial year brings me very close to the end of my term as ACRRM president. It has been three years of profound progress for our college and of hopes and aspirations becoming reality. It has been a time during which ACRRM has come from relative obscurity to being at the international leading edge of providing professional support for the discipline of rural medicine. Above all else, however, it has been three years of living a great privilege. I have had the privilege of being at the head of a college in which hundreds upon hundreds of members and staff have plumbed the depths of their souls to find immeasurable reserves of courage, commitment and innovation. It has been a great three years.

Professor Ian Wronski
President of ACRRM

RURAL Health & RURAL Medicine

Throughout the world, in both developed and developing nations, there is urgent concern about the poor health of rural communities and their limited access to health care. Generally, consideration of the health of rural communities leads not only to new health programs targeted specifically at those communities but also to consideration of the need to ensure a better supply of properly trained health professionals. This, in turn, has driven recognition of the special needs of health professionals in rural areas, clarifying and defining their roles, and development of training programs specifically for rural practitioners.

The provision of primary and secondary medical services to rural communities entails a number of complexities that require special training and, until steps are taken to provide the right kind of training, there will never be enough medical practitioners prepared to work in rural areas. In addition, many rural practitioners will struggle to provide a quality service because they have not been prepared for the lack of direct access to allied health and specialist services. Solving rural health problems cannot be separated from consideration of appropriate recruitment and training of rural health professionals, including practitioners of rural medicine.

While interesting recruitment and training developments have been taking place in several countries, Australia leads the way in recognition, vocational training and ongoing professional development of practitioners of rural medicine. Australia is in this position principally as a consequence of the pioneering, innovative work undertaken by the Australian College of Rural and Remote Medicine.

The Status of Rural Health

It is too easy to presume that in a developed nation all citizens will benefit from quality health care and all will have good health. In reality, within most countries, developed and developing, there are inequities in access to health care and health outcomes. In most countries, citizens living in rural areas have poorer standards of health than their urban counterparts.

"Around the world, the health status of people in rural areas is generally worse than in urban areas. ... In general, the rates of avoidable deaths in rural and remote areas are higher than in the cities. Generally, work injuries are more serious and more severe in rural areas, which to some extent follows from the stoicism and the 'too tough to care' mindset particularly amongst farmers and agricultural workers. In fact, in Australia, the tractor is the most dangerous machine with which people work. Forty percent of work injuries are associated with tractors, even though only 5% of the workforce actually works with tractors. Similarly, there are dangers in other rural pursuits such as mining, fishing and timberwork. In countries with established highway systems, country people spend a lot of time driving at high speed and tend to have more serious injuries from motor vehicle accidents. ..."



Roger Strasser, Rural health around the world: challenges and solutions, Family Practice Vol 20 No 4, Oxford University Press 2003



About 30% of Australians live in rural areas and a number of key measures demonstrate they have poorer health than their urban counterparts, especially compared to the 9 out of 10 urban dwellers who live in capital cities. Australian males living in rural areas live about a year less than their city counterparts and four years less if they live in remote areas. Australian females living in rural areas fare a little better, living about half a year less than their city counterparts but if they live in remote areas they also have four years less of life. Death rates for males and female Australians living in capital cities are 6% lower than for those living in large rural centres and 20% lower than those living in remote regions. Deaths arising from injuries for males in remote areas are double those of their city counterparts and for those living in rural areas are 50% higher. Both males and females from rural areas die in road accidents at double the rate of their city counterparts.

Figures from Health in rural and remote Australia, Australian Institute of Health and Welfare, Canberra 1998.

Although 30% of Australians live in rural areas, only about 10% of the nation's doctors practice in those areas. There have been chronic shortages of medical practitioners and other health care professionals throughout rural Australia for decades, with a current shortfall of at least 1,200 medical practitioners, and the situation is becoming worse. This factor alone militates against equity of access to health care in rural Australia, but there are other factors making the situation even worse.

The distribution of the rural population, scattered across large distances, results in restricted access by patients to the full range of tertiary hospital facilities, specialists and allied health services. Service provision becomes even more complicated where emergencies and accidents occur in remote and isolated locations. Transfer may be available but often involves delays necessitating primary stabilisation and treatment before transfer.

Rural and Remote Medicine

Medical practitioners providing primary health care in rural areas must provide services with less support immediately available and with fewer opportunities for referrals. They are under immense pressure and this, in turn, makes rural practice less attractive. There have been ongoing difficulties in attracting medical practitioners to rural areas and the principal reasons are the poor quality lifestyle that results from the immense demands of rural practice, inadequate financial remuneration and predominantly metro-centric training that fails to reflect the realities of rural practice.

Making rural medical practice attractive, so that there will be a greater supply of practitioners and improved health outcomes for rural communities, begins with recognising the distinct nature of rural practice, providing training specifically for rural practice and providing better support for rural practitioners. In short, improving rural health means acknowledging the special needs of practitioners of rural medicine.

Recognition that rural medicine is a separate medical discipline, and supporting that discipline, is increasing around the world as different countries tackle health care in rural communities. They are not only taking steps

to introduce health programs specifically for rural communities but also introducing training arrangements specifically for primary health care professionals who will be providing services for rural and remote areas. Postgraduate qualifications in rural health and rural medicine are becoming more common and a number of overseas universities have established Chairs/ Professorships in rural medicine.

These developments are a response to increasing recognition that metro-centric medical training has denied the reality of the discipline of rural medicine and has deterred medical graduates from pursuing careers in rural communities.

Recognition of the discipline of rural medicine has come in a number of forms, including the establishment of specialist organisations such as ACRRM and the Society of Rural Physicians of Canada.

The Importance of Rural Training

Medical training for rural skills and in rural locations is critically important in ensuring an adequate supply of doctors who will make the commitment to work in rural communities and who are confident they have appropriate skills for the demands that will be made on them. There is recurring evidence that the right training will reduce the likelihood that rural communities are under-serviced in terms of their health needs in the future.

The summer 2001 issue of the Canadian Journal of Rural Medicine reports on a research project that shows that:

"... rural training was significantly associated with practice location choice. Those residents with some rural training in their family medicine program were more likely to choose a non-urban practice location.

... In this study, any relationship of confidence in procedural skills to choice of practice location was overshadowed by the rural training variable because rural training has many more components than just procedural skills training that may influence practice location choice. Such features as rural environment, lifestyle and practice style are all part of the rural practice experience and may play important roles in the decision to choose rural practice. ..."

Exit surveys of participants in the first four years of the RRAPP program managed by ACRRM are equally revealing of the important relationship between rural training and choosing to work in rural locations.

Although only 44% of participants had rural origins, 95% expressed interest in future involvement in rural practice. Overall, 74% of participants say that involvement in RRAPP has influenced their choice of career path.

One of the more profound reasons that doctors leave rural practice is concern that they may not be able to maintain their wider skills base. At the same time, the scope and variety of practice, professional autonomy, the opportunity to undertake procedural medicine and scope for continuity of patient care are often cited reasons for staying in rural practice. Training and support for practitioners of rural medicine must ensure they acquire the skills necessary for these circumstances and professional development programs must ensure they can easily maintain and update their unique mix of skills.

ACRRM's curriculum for rural and remote medicine and its professional development program provide the basis for Australia to revitalise the appeal of rural medical practice and to start the process of turning round rural health inequities. The establishment, growth and powerful innovations of ACRRM put Australia at the forefront of all nations trying to bring health justice to their rural citizens.

CEO's REPORT

The 2002-2003 financial year was somewhat of a watershed for the management of ACRRM because it was the first time the availability of our programs offered real choice for rural doctors. The Federal Government's decision late in 2002 to recognise ACRRM's professional development program (PDP) for maintenance of VR meant members of the college had a new option. They could decide whether they did a rural medicine program or a general practice program. We had been told that our product was superior but these circumstances made it a genuine competitor in the marketplace.

The early part of the financial year had involved considerable negotiation to ensure the Federal Government followed through on the commitment made toward the end of 2001 by the previous Minister for Health, Dr Michael Wooldridge. His successor Senator Kay Patterson was new to the portfolio and it took 12 months to get an agreement in place that delivered at least part of the Federal Government's original commitment.

One of the factors contributing to delays was major change in the Department of Health and Ageing, both in terms of structure and staffing. Existing relationships and corporate knowledge were lost. However, considerable goodwill remained and new and effective relationships have been built. ACRRM continues to value its working relationship with the Department.

While the negotiations around the VR role were taking place, ACRRM was undertaking considerable work with regional training providers, especially in terms of assisting them to increase the number of rural practices that were accredited to provide training. ACRRM also worked with training providers to develop content for registrars and with some of the training consortia to develop a pathway to the ACRRM fellowship. In fact, ACRRM undertook pioneering work with a number of

regional training providers wanting to offer the ACRRM fellowship as a core part of their training suite. ACRRM has always committed itself to supporting programs and pathways to careers in rural and remote medicine.

Another task receiving attention was finalising of work carried out under the Integrated Models of Medical Education (IMME) grant that had been given to ACRRM in 2000. This was the first Federal Government grant that recognised ACRRM's role in vocational training, professional development, teacher support and change management. The primary purpose of the grant was to support the introduction of the 'regionalisation' of training and it was appropriate that it go to ACRRM because our college had developed strong expertise in key areas and has always been a champion of regionalised vocational training. The Government was keen to ensure there were appropriate regional structures and functional regional training providers to ensure the new approach to training would work. The grant ensured ACRRM had enough resources to engage with stakeholders and share knowledge and ideas.

From this very dynamic and productive year we have learned key lessons for the future. One of the biggest things that became clear was for policy positions and operational issues to be well aligned and clear when agreements are made. The slow progress in encouraging the Federal Government to follow through on its commitment to formalise ACRRM's role in professional development just re-emphasises the need to thoroughly document actions and decisions. From a management perspective it became even clearer that when an organisation is very busy, especially when resources are limited, that activities and goals must be strongly integrated, all aspects of work must complement each other.

Finally, it has once more been confirmed that one of ACRRM's greatest strategic advantages is the drive, commitment and hard work of members, the board and staff. We continued to rely heavily on member input to policy development and program reviews. We also continue to rely on a strong partnership between board members and staff to pursue our priority objective. Throughout the year we retained a small, expert staff that has always had the capacity to deliver quality work with minimum resources. Our staff members are very loyal and focussed on outcomes. No other college can boast such a skilled team, such low staff turnover and such high morale. Having skilled and stable staffing arrangements means corporate knowledge is retained and there is a capacity to move quickly in response to sudden changes within the political environment.



Marita Cowie
Chief Executive Officer, ACRRM

The Establishment of GPET

Although there had been a mixed response across the medical profession to the establishment of the Government's new entity General Practice Education and Training (GPET), ACRRM was openly supportive from the outset. ACRRM saw regionalisation as essential for effective training for rural practice and for supporting rural communities.

ACRRM is solutions oriented and innovative. Ours is not one of those organisations stuck in the past and doing things a certain way for no better reason than they have always been done that way. When the Government took appropriate action to regionalise training we gave full support. From the outset ACRRM has assisted GPET to be innovative and to think laterally in exploring solutions to rural workforce problems and rural education. It would be fair to say that without ACRRM's wholehearted support it would have been much more difficult for GPET to achieve its objectives.

GPET needed to focus on the future and having a new college with modern ideas and structured on modern education principles meant the two organisations could complement each other and work well together. We also have a very close connection with rural communities and rural organisations so we were in a position to act as an advocate for the training consortia as they were starting out. We played a significant role in ensuring inappropriate systems and processes were not foisted upon small developing groups - it was critically important that there not be a level of red tape that would tie up limited resources and yield little reward for the time invested.

The ACRRM Strategic Plan

Although urgent political priorities drained resources, ACRRM remained focused on the board's strategic plan and it gave core priority to developing standards and documenting the curriculum. Consistent with this priority, the second edition of ACRRM's curriculum became available during this period. In addition, the vocational training pathways document was being amended in response to regionalisation. The professional development policies and processes were being refined - this largely became the platform for the Federal Government to approve the vocational registration arrangements that are now in place. ACRRM also started work on and finalised standards for teaching practices. We started work on practitioner standards, codes of conduct and other key documents that are still works in progress.

The highest priority was the education programs, standards for training and professional development. Largely, the board's strategic plan focused on those areas, along with starting development of the ACRRM assessment pathways, and we started modelling these during the financial year.

Rural and Remote Education Online (RRMEO)

Throughout this watershed year, Rural and Remote Education Online (RRMEO) received a lot of energy and attention and had a virtual launch by ACRRM's president. Prof Ian Wronski during a satellite broadcast. Eight institutions, mostly regional training providers, were early adopters of the system and we went through an intensive process of refining it to accommodate their feedback and to generally make it simpler and more intuitive to use.

Rural and Remote Medical Education Online (RRMEO) was developed by ACRRM to break down some of the barriers to upgrading skills and knowledge for doctors in rural and remote locations. It is the world's first online learning platform designed and built specifically for rural doctors. It supports both the ACRRM professional development program and vocational training for registrars.

RRMEO is a suite of powerful electronic tools that assist doctors in the management of information and professional education requirements. It is easily accessible via an Internet browser and requires only basic computer knowledge.



RRMEO allows ACRRM members to search an ever-expanding database of educational events (both on and off line), training posts and educational resources (e.g. validated websites, downloadable protocols).

ACRRM members can also record their educational activities in a personalised learning planner that not only records

all activities undertaken on RRMEO, but also allows for the entry of external activities. Members simply submit their learning planner at the end of their educational program for approval by credentialing organisations.

During July 2002 usage of RRMEO began its rapid upward trend with the number of separate users doubling to 1200 and over 55,000 pages of content being accessed. Throughout the financial year the number of doctors finding the RRMEO system to be practical and helpful grew at a strong pace and the number of separate users had escalated to over 3,000 every month with 93,000 pages of content being utilised in June 2003.

Commitment to quality and innovation means never resting on your laurels. RRMEO modifications throughout the financial year included increasing the functionality of the learning planner, merging of the learning portfolio into the learning planner, the introduction of an instant enrolment process and adding extra reporting functionality. The future for RRMEO includes release of new online modules on palliative care, practice management, mental health, dermatology, digital photography, and teach the teacher. To facilitate further modification of the system and streamlining of processes, we have established a RRMEO focus group with representatives from all RRMEO consortia and other interested parties to provide advice and suggestions. It is expected that this group will be the major driver for future RRMEO development.

Professional Development Program

The ACRRM professional development program is structured around a quality assurance framework that was set up to ensure the college was able to utilise international best practice to verify to relevant agencies, and the broader public, that fellows of the college are participating in ongoing education, are keeping up to date with their skills and protecting the safety of their patients. The professional development program has been based on this principle and has been written with the needs of rural doctors at the forefront of design because rural and remote medicine is a broad discipline with many dimensions.

One of the problems with other forms of professional development, and the reason other college professional development structures have not suited rural doctors well in the past, is that they tend to be based on one core discipline with a series of add ons and options. For example, a program based on general practice model would need added content for procedural work, anaesthetics, radiology and so forth. The difficulty is that, given the many facets of rural medicine (needing a broader range of skills and a deeper understanding in certain areas of skill), the resultant multiple credentialing requirements needed to maintain all relevant requirements leads to 3-4 times the amount of work that normal urban practitioners would have undertaken to demonstrate their ongoing competency. ACRRM set out to streamline all of those requirements and pull them into a system that reflected the various skill sets and the various depths of knowledge that are the hallmarks of rural medicine.

ACRRM designed a streamlined system that took a holistic approach because all of the research showed that one of the biggest barriers to remaining in rural practice was being able to maintain broad skill set to a high level of accountability. ACRRM designed its PDP to overcome the barriers that were frustrating rural doctors. The framework was written by a committee with board member representation and it was led by Professor David Wilkinson, Adelaide University.

One of the major outcomes of a professional development program is to be able to demonstrate to other agencies, third parties, that fellows have met their obligations. ACRRM accepts responsibility on behalf of members for informing the various medical registration boards, the HIC and the joint consultative committees and/or hospital clinical privileging boards about compliance with their requirements by ACRRM members.

The ACRRM professional development program is recognised by the Royal New Zealand College of General Practitioners.

Research & Advocacy

On 1 March ACRRM, in conjunction with RDAA and RWAG, held a procedural medicine symposium as part of the National Rural Health Alliance's conference in Tasmania. The symposium was a significant initiative that ensured procedural medicine was noticed on the Federal Government's radar. It was put on the agenda following ACRRM research that identified barriers to attaining and maintaining procedural skills. Jointly with RDAA and RWAG, ACRRM put together a solutions paper and then held the symposium. This led to a series of meetings with the Australian Health Ministers' Advisory Council (AHMAC). A range of solutions and recommendations were put forward. ACRRM also worked with the rural and remote committee of the General Practice Advisory Council (GPAC) to ensure the key issues for procedural doctors were addressed at the national level. Ultimately, all of this engagement resulted in Federal Government initiatives to support education and service delivery.

Women in Rural Practice

ACRRM went through a process of reviewing both internal research into members' needs and what other agencies, particularly the rural workforce agencies, had been doing state by state. ACRRM reviewed what the range of needs analysis and research was showing and, putting it together with internal research, synthesised at a national level what people were saying generally and what was being articulated within the ACRRM membership. After completing the work we were able to indicate whether the views of ACRRM female doctors were consistent with national findings. In fact, there were significant areas where female ACRRM members had different needs, different perspectives and priorities. One significant finding was that ACRRM female members felt very strongly about the need for their style of practice (rural and remote medicine) to be recognised. They saw lack of appropriate recognition as a key barrier to their professional practice. On the other hand, non-members allocated higher priority to other issues. There was substantial common ground, however, across recognising and identifying issues.

The Early Years of Training: Enhancing the Pathways

The depth of ACRRM's interest, support and advocacy extends from student to professional development. In terms of career paths our aim is to engage people as early as possible to give them a positive exposure and experience in rural practice. Prior exposure and ongoing support are prerequisites for independent confident practice. They are essential for success in any medical discipline but are particularly important in rural and remote medicine where ready access to other specialists is generally not viable.

ACRRM has a range of initiatives that begin at high school level where we support other groups to foster interest in medicine as a career.

Every year ACRRM provides an award for an undergraduate student from the National Rural Health Network at their annual conference. The prize is a two-week practice placement at a location of the student's choice. ACRRM also assists with practice selection, if necessary. This award has seen many undergraduate students undertake enlightening and rewarding placements in a variety of remote communities such as Christmas Island and Thursday Island.

John Flynn Scholarship

ACRRM tendered for and won the contract to administer the John Flynn Scholarship Scheme (JFSS). Work includes managing the scholarship payments, providing access to RRMEO and supporting junior doctors in making sure their expectations of rural communities are realistic and appropriate.

ACRRM seeks to ensure the success of the scheme by ensuring junior doctors are well supported through good placement and good experiences. ACRRM facilitate a worthwhile experience by supporting positive interaction in the practice and the community. Scholars provide reports to reflect on their experience and ACRRM troubleshoots any problems they experience.

Medical Rural Bonded Scholarship Scheme

Another success for ACRRM was winning the bid for supporting the medical rural bonded scholarship scheme. ACRRM doesn't administer the scholarship scheme but runs a support program for the scholars in the program, including access to RRMEO, providing an opportunity to interact with rural doctors in a virtual community. ACRRM also provides peer-networking support and advertises and promotes a series of relevant rural medical conferences.

Rural and Remote Areas Placement Program

ACRRM's Rural and Remote Areas Placement Program (RRAPP) is a junior doctor initiative, targeting graduate medical students who have not yet selected a specialty for vocational training. Normally graduates spend a year or two in the hospital system and, typically, would not have any exposure to remote practice or private practice. ACRRM introduced RRAPP as a vehicle for junior hospital doctors to have a term (12 weeks) where they can rotate out to a rural area and work out of a rural practice to have exposure to that type of medicine before they make their decision regarding which specialty to pursue. RRAPP has been the only program in Australia that gives junior doctors this opportunity. The value of RRAPP has been a stimulus to the Federal Government including provision within the Medicare Plus package for seventy places for general practice registrars and rural medicine registrars to experience non-hospital practice. This Federal Government decision is yet another action to benefit rural communities and practitioners of rural and remote medicine that has arisen entirely as a consequence of ACRRM's pioneering and innovative approach to solving problems.

The ACRRM Fellowship

As the arbiter of standards for practice of rural and remote medicine, ACRRM awards a fellowship to medical practitioners who have demonstrated they have attained the necessary skills, knowledge, behaviours and experience to be considered a qualified specialist in the discipline of rural and remote medicine. It is the most prestigious award conferred by ACRRM. The names of successful candidates for fellowship are added to the college's vocational register. Members awarded the fellowship maintain their qualification by participation in professional development programs that are relevant and accredited for rural practice

The process for awarding the fellowship has evolved but the underlying constant consideration is best practice in rural and remote medicine. In 1998 ACRRM finalised criteria for best practice and practitioners with substantial qualifications and experience who meet all the requirements of the criteria became eligible for fellowships. There are two broad pathways to achieve fellowship of ACRRM: one is a vocational training pathway and the other is the experience-based pathway.

Within the vocational pathway there are three program options. There is a vocational preparation option run through GPET and the regional training providers: the structured four year rural training pathway. The second is the independent pathway for experienced doctors where there is significant prior learning to be recognised. ACRRM's censors assess previous experience and work, and then tailor a program to meet the balance of requirements for fellowship. It is more flexible and self-directed than the vocational preparation pathway. The third option in the suite of training pathways is the remote vocational training scheme. This is run jointly with the RACGP and is a remote program that allows doctors to remain in their community while completing training. Most of the training within the remote vocational training scheme is delivered by distance through RRMEO and teleconference tutorials. There is also a series of face-to-face workshops but there is no face-to-face daily or weekly contact with supervisors. Candidates for this pathway tend to be quite experienced and independent.

For all three training options there are appropriate assessment requirements but they vary. Assessment may include formal written exams, formative assessment, supervisor assessment, and

regional training provider reports.

The other broad pathway to ACRRM fellowship is the experience-based pathway. It is judged against the fellowship standard but is awarded following an intensive process of reviewing and recognising past experience and the evidence available for knowledge and skills acquired through that experience. Within the review by a committee of censors there is recognition of a variety of prior training and assessment. Following the review, the fellowship may

be awarded, specific training may be required or, in some cases, there will be a requirement to sit a formal examination. ACRRM's inaugural fellowships were awarded via a pioneer experience-based pathway.

While ACRRM's censors must be convinced that the standard is being met and must be provided with sufficient documentation and evidence before awarding a fellowship, they also believe very experienced doctors, for example doctors trained overseas, should not be required to sit for what are very junior exams compared to their level of experience. If they are able to document and demonstrate to the college censors, to a satisfactory level, that they are experienced and skilled then this contributes toward their assessment for fellowship. Current skills, knowledge and behaviours are taken as the starting point.

The standard for rural and remote medicine

Candidates for the ACRRM fellowship must demonstrate the broad range of skills and competencies required for diagnosis, investigation and management of common conditions and presentations in rural practice in internal medicine, surgery, obstetrics and gynaecology, paediatrics, and psychiatry. They must also be competent in managing pre-anaesthetic conditions and those requiring local anaesthesia. In addition, competency is required in utilisation of information from diagnostic disciplines in the management of conditions in rural practice.

Other requirements for award of the fellowship are high quality primary and secondary care in rural practice according to community needs and geographic conditions, effective communications and empathy with patients, relatives and community members, and effective taking of histories, conduct of physical examinations and undertaking of procedures in the management of common conditions in rural practice.

In determining requirements for the award of the fellowship, ACRRM recognises that Aboriginal and Torres Strait Islander people are more likely to be patients and their health issues more likely to be a major component of overall community need in rural and remote settings. Accordingly, candidates for the fellowship must demonstrate an understanding of the social, cultural, historical, economic and political framework that has influenced the current health status of Aboriginal and Torres Strait Islander people. They are also required to demonstrate culturally safe practice and diagnosis, investigation and management of common conditions and presentations for Aboriginal and Torres Strait Islander people. Where a practitioner has not had sufficient exposure to meeting the needs of Aboriginal and Torres Strait Islander communities, the censors may ask for an attachment and ACRRM would facilitate this.

Another key prerequisite for award of the ACRRM fellowship is relevant knowledge, skills and attitudes related to emergency care, population health, professional and ethical practice, and the rural and remote context. This context requires effective practice unsupported by ready access to specialist services and with an understanding of the social, economic and political issues impact on the health of people in rural and remote areas. It is expected that candidates for the fellowship will have a core level of trauma, resuscitation and retrieval skills and be cognisant of the mortality and morbidity issues are unique to rural communities.

Financial Statements

FOR THE YEAR ENDING 30 JULY 2003

The Director's Report

The Directors submit the following report for the year ended 30 June 2003 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:

Professor Ian Wronski
Dr Alan Bruce Chater
Dr Jane Greacen
Dr Brian Bowring
Dr Wynand Breytenbach (resigned 2/11/02)
Dr John Brown (resigned 2/11/02)
Dr Bruce Cameron
Dr David Campbell
Dr Mark Foreman (appointed 2/11/02)
Dr Stephen Holmes
Dr Daniel Pettersson (resigned 2/11/02)
Dr Leslie Woollard (appointed 2/11/02, resigned 13/4/03)
Dr John Heinrich (appointed 2/11/02)
Professor Roger Strasser (resigned 4/8/02)
Professor John Murdoch (appointed 15/1/03)
Dr Ruth Stewart (appointed 2/11/02)
Dr Ian Kamerman (appointed 1/6/03)

PRINCIPAL ACTIVITIES

The principal activity of the Company during the year ended 30 June 2003 was the provision of medical education and training services to 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 2003 amounted to \$2,213,196 (2002: \$233,174 deficit). This surplus is made up of a College surplus of \$166,444 and a project surplus of \$2,046,752.

The project surplus of \$2,046,752 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 cut-off. 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 will apply to the Australian Medical Council in early 2004 to have Rural and Remote Medicine recognised as a distinct medical speciality. The College is pursuing this recognition in order to have the specialist medical skills and knowledge acknowledged, and the education and training programs that lead to these attributes accepted as the official standard for practice in the field. This will be increasingly important if enhancements are made to the system of registration of medical practitioners. Recognition for the purposes of the Health Insurance Act, 1973 will also be sought through the application so that rural medical practitioners can gain authority to render services that attract a Medicare benefit.

The College will continue to provide high quality education and training services to rural and remote medical practitioners in Australia. It will expand its role in developing and maintaining 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. A formal assessment process for Fellowship of ACRRM is also under development and is expected to be available in 2004.

The College will continue to build and consolidate its efforts to provide flexible distance education programs and maximise the benefits of its online learning system, RRMEO. Particular priority will be placed on engaging medical training providers, marketing the partnerships created through the system, and continuing to build on its past achievements in providing high quality educational materials and curricula.

Project management and development for a range of medical education and training initiatives will continue to be provided by the College. In particular the College anticipates a significant component of project based work stemming from initiatives funded by the Commonwealth Department of Health and Ageing.

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.

Prof Ian Wronski

MBBS (Monash), Dip RACOG, FRACGP, DTM&H (Liverpool), MPH (Harvard), SM [Epi] (Harvard), FAFPHM, FACTM, FACRRM

Professor Ian Wronski is the current President of ACRRM. He has been a member of the College since its inception in 1997 and is a Foundation Fellow of ACRRM. Professor Wronski has been an active member of College committees at national, state and regional levels including Chair of the ACRRM / RACGP Joint Venture Board. He has 25 years' experience in rural and remote, public and indigenous health at both a clinical and health planning level. He also holds a number of senior academic appointments including Executive Dean, Faculty of Medicine Health and Molecular Sciences at James Cook University; member of the Committee of Deans of Medical Colleges; member of the Committee of Deans of Health Science Faculties and the Ministerial Health Services Advisory Committee.

Dr Alan Bruce Chater

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

Dr Bruce Chater is the Vice President of ACRRM. He is a founding member and Fellow of ACRRM with more than 20 years' experience as a solo procedural practitioner in small community of Theodore in Central Queensland. Dr Chater has also had a longstanding involvement in the medico-political and educational policy arena in Australia. He has held a range of positions including President of the Rural Doctors Associations of Queensland and Vice President of Rural Doctors Association of Australia, Chair of the National Rural Health Alliance and Rural Faculty representative on the Council of the RACGP. He is currently the Australian delegate to the WONCA International Rural Working Party, a Director on the Board of the National Institute of Clinical Studies, and a Director representing ACRRM on the Rural and Regional Queensland Training Consortium. He is a Senior Lecturer in Rural Medicine.

Dr Jane Greacen**MBBS, MPH, FAFPHM, FACRRM**

Dr Jane Greacen is the current Treasurer of the College and ACRRM representative on the Council and Executive Committee of the National Rural Health Alliance and it's Treasurer. Dr Greacen practices as a rural doctor and is also the Chief Executive of the Rural Workforce Agency Victoria. Her special areas of interest include the promotion of female rural doctors, the supply of medical workforce to Aboriginal Medical Services and the support of education and training for and by rural practitioners.

Dr Brian Bowring**MBBS (Tas), DRANZCOG, FRACGP, FACRRM**

Dr Brian Bowring is the Tasmanian Director on the ACRRM Board. Dr Bowring practices in Georgetown Tasmania and has been a rural practitioner for 17 years. He has been an active participant in many ACRRM committees, the Rural Doctors Association of Tasmania, Rural Doctors Association of Australia and Divisions of General Practice. He is currently the ACRRM representative on the Tasmanian GP Training Consortium, Chair of the Board of the Tasmanian General Practice Divisions (incorporating Rural Workforce Support Agency) and Chair of the Rural Workforce Support Committee of that organisation. Dr Bowring is also Chair of the Rural Health Education Foundation and Chair of the Sea College George Town Board of Management.

Dr John Brown**MBBS Hons (Sydney), Dip RACOG, FACRRM**

Dr John Brown is the NSW Director on the ACRRM Board and is Foundation Member and Fellow of the College. He currently practices at Narooma on the south coast of NSW after moving from Mudgee after 23 years. Dr Brown has served as a member of the Rural Doctors Association of NSW since 1998 and is a member of the NSW Medical Board's Area of Need Panel that assesses doctors' suitability for appointment in Areas of Need. He also holds a number of other health related appointments and committee roles within ACRRM and his community. His areas of clinical interest include skin cancers and men's health.

Dr Wynand Breytenbach**MBChB, FACRRM, FRACGP**

Dr Wynand Breytenbach is the Western Australia Director on the ACRRM Board and currently works as a rural doctor in Dalwallinu, 250km north of Perth. He graduated in 1983 from the University of Free State in Bloemfontein, South Africa and worked for 11 years as a procedural GP in South Africa before moving to Australia in 1998. Dr Breytenbach is a member of the Central Wheatbelt Division of General Practice as well as ACRRM nominee to the Board of West Australian General Practice Education Training Inc., which is the regional training provider for generalist training in Western Australia. His clinical special interests include Emergency Medicine, Obstetrics, Sports Medicine and training.

Dr Bruce Cameron**FACRRM, DRANZCOG, BSc Hons (Geophysics)**

Dr Bruce Cameron is the Queensland Director on the ACRRM Board. Dr Cameron is a Foundation member and Fellow of ACRRM and practices in Atherton, Far North Queensland. Dr Cameron is the ACRRM representative on Queensland's General Practice Advisory Committee and the State's Medical Workforce Advisory Committee. He is the Far North Queensland Rural Division of General Practice representative on the Tropical Medical Training consortium and a member of the Far North Queensland Credentialling and Clinical Privileging Committee. Dr Cameron has previously held positions as President of the Rural Doctors Association of Queensland, Vice President (Education) of Rural Doctors Association of Australia, and Board member of the Queensland Rural Medical Support Agency.

Dr Bruce Cameron**FACRRM, DRANZCOG, BSc Hons (Geophysics)**

Dr Bruce Cameron is the Queensland Director on the ACRRM Board. Dr Cameron is a Foundation member and Fellow of ACRRM and practices in Atherton, Far North Queensland. Dr Cameron is the ACRRM representative on Queensland's General Practice Advisory Committee and the State's Medical Workforce Advisory Committee. He is the Far North Queensland Rural Division of General Practice representative on the Tropical Medical Training consortium and a member of the Far North Queensland

Credentiailling and Clinical Privileging Committee. Dr Cameron has previously held positions as President of the Rural Doctors Association of Queensland, Vice President (Education) of Rural Doctors Association of Australia, and Board member of the Queensland Rural Medical Support Agency.

Dr David Campbell

MBBS, Dip RACOG, FRACGP, DCH, FACRRM

Dr David Campbell is the Victorian Director on the ACRRM Board. He has practised as a rural doctor in Lakes Entrance in Victoria since 1983 and is a Foundation Member and Fellow of ACRRM. He currently holds an appointment as Senior Lecturer at the Monash University School of Rural Health. He is a Director and Board member of the Rural Workforce Agency Victoria and a member of the Committee of Management of Rural Doctors' Association of Victoria. Dr Campbell is a Director of the Gippsland Education and Training for General Practice consortium. He chairs the ACRRM Accreditation Committee and Emergency Medicine Teacher Training Committee and is a member of the Pilot Remote Vocational Training Stream Committee between ACRRM and RACGP.

Dr Mark Foreman

MBBS, FACRRM, MRACMA, MPF&TM, DTM

Dr Mark Foreman is currently a locum in SA and the NT and has spent a total of 7 years in rural or remote practice. Areas of interest include Anaesthetics, Intensive Care, Tropical Medicine and Public Health. Up until May 2003, he was a member of the ACRRM Board and Medical Superintendent of the Katherine Hospital, NT. Dr Foreman has previously worked with the Australian Defence Force and International SOS, including positions in Indonesia and Papua New Guinea.

Dr Stephen Holmes

MBBS (Adelaide), FACRRM, FRCPA, DRACOG

Dr Stephen Holmes is 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 1986. He chairs ACRRM's Professional Development Committee and IMIT Committee and represents the College on the Quality Use of Pathology Committee, General Practice Computing Group Management Committee and chairs the SA GP Forum. Dr Holmes is a member of the Executive Committee and Lower Mid-North representative on the Mid-North Medical Practitioners Association and Mid-North Division of General Practice. He is a life-member of South Australian Post-Graduate Medical Education Association.

Dr Daniel Pettersson

MB ChB (Sheff), FRACGP, FACRRM

Dr Daniel Pettersson is the Registrar Director on the ACRRM Board. Dr Pettersson came to Australia in 1995 and is currently a fulltime procedural Rural Doctor in Leeton NSW. He has been an active member of a number of ACRRM committees at national, state and regional levels. He is a foundation member of the Doctors In Rural and Remote Training Association. His areas of special clinical interest are trauma and palliative care.

Dr Les Woollard

MB ChB (Sheff), FRACGP

A rural GP for 21 years, Dr Woollard practices in Moree in nort west NSW, doing GP, Anaesthetics, Obstretics etc and is a VMO at the local hospital. Dr Woollard was appointed as an Executive ember of the Rural Doctors Association of NSW in 2002 and on the Barwon Division GP Board since its inception to 2002. Dr Woollard is also on the Steering Committee for Procedural GP Training with NSW Health.

Dr John Heinrich

MBBS (Qld), FACRRM, Graduate Certificate in Family Medicine (Monash), FRACGP

Dr John Heinrich is currently in Mundubbera, a small ton of 2500 people, where he is the Medical Superintendent of the local hospital and a solo rural medical practitioner. He has also practiced in Blackall as a solo rural medical practitioner and has been an enthusiastic participant in the PRVTS. He has been the ACRRM Registrar Director since October 2002, a position he obtained whilst he was a PRVTS registrar. Dr Heinrich is also on the GPRA Board.

Prof Roger Strasser**MBBS, BMedSc, MCISc, DA, Dip RACOG, FRACGP, FACRRM**

Professor Roger Strasser is the Academic Director on the ACRRM Board. Until his recent appointment as the founding Dean of the Faculty of Rural Medicine at the University of Western Ontario, Canada, Professor Strasser was Director of Monash University Centre for Rural Health and a part-time rural doctor at Traralgon, Victoria. Professor Strasser has worked in rural, vocational training, education and research for many years. He is the founding and current Chair of the WONCA Working Party on Rural Practice. A Foundation Member of ACRRM, Professor Strasser has played a significant role in the development of the ACRRM curriculum.

Prof John Murdoch**MD PhD, FACRRM, FRACGP, FRNZCGP, FRCGP**

Professor John Campbell Murdoch is the Professor and Head of Rural Clinical School at the University of Western Australia. He was a family physician in rural practice in Winterton, Southland, New Zealand. He was also Professor and Chair of the Department of General Practice, Dunedin School of Medicine from 1983 to 1992 and a pioneer in research and clinical management of chronic fatigue syndrome at the time when the syndrome had a high prevalence in New Zealand. He is also worked in both the Middle East and the UK. Professor Murdoch has just co authored a book with Harriet Denz-Penhey; titled "Chronic Fatigue Syndrome, a Patient Centered Approach".

Dr Ruth Stewart**MBBS, DRANZCOG, FACRRM**

Dr Ruth Stewart is a part-time GP in Camperdown, Western Victoria, a town of 3500. Ruth, her GP husband Tony Brown and their four children live in town. Ruth is a procedural GP obstetrician with Caesarean skills and she joins in the weekend on-call roster for Camperdown hospital. Making life better for rural women practitioners is a high priority for Ruth who is a committee member of the practice standards taskforce, the accreditation advisory group, and the procedural skills taskforce.

Dr Ian Kamerman**MBBS, FACRRM, DRANZCOG, DA**

Dr Ian Kamerman has recently been appointed as the NSW Director on the ACRRM Board. Dr Kamerman is a foundation Fellow of the College and well-known advocate for Rural and Remote Medicine. He has worked in the Bingara and Junee regions of the state for nearly a decade now but has also practiced in various regions throughout country Victoria. He has completed many degrees including a Bachelor of Medicine & Bachelor of Surgery at The University of Sydney; a Diploma of Obstetrics at The Royal Australian and New Zealand College of Obstetricians and Gynecologists; and a Diploma of Anesthetics at The College of Anesthetists; and a Corporate Directors' Diploma Course at The University of New England.

MEETING OF DIRECTORS

During the financial year, 11 meetings of directors were held, with attendance as follows:

DIRECTORS	Directors Meetings	
	Eligible to attend	Attended
Professor Ian Wronski	11	9
Dr Alan Bruce Chater	11	11
Dr Jane Greacen	11	11
D Brian Bowring	11	7
Dr Wynand Breytenbach	4	3
Dr John Brown	4	3
Dr Bruce Cameron	11	10
Dr David Campbell	11	11
Dr Mark Foreman	7	5
Dr Stephen Holmes	11	10
Dr Daniel Pettersson	4	4
Dr Leslie Woollard	5	5
Dr John Heinrich	7	6
Professor Roger Strasser	1	1
Professor John Murdoch	5	4
Dr Ruth Stewart	11	9
Dr Ian Kamerman	1	1

ATTENDANCE OF EX OFFICIO BOARD MEMBERS AT THE MEETING OF DIRECTORS

EX OFFICIO MEMBERS	DIRECTORS MEETINGS	
	Eligible to attend	Attended
Dr Lexia Bryant, Immediate Past President	11	8
Dr Tom Doolan, Hon. Director of Education	11	8
Dr Mark Robinson, Censor	8	5
Ms Marita Cowie, Chief Executive Officer	11	10

There is two formally constituted committee of the board being the Executive Committee and Audit Committee. During the financial year, 8 meetings of the Executive Committee were held, with attendance as follows:

EXECUTIVE MEMBERS	Executive Meetings	
	Eligible to attend	Attended
Professor Ian Wronski	8	7
Dr Alan Chater	8	8
Dr Jane Greacen	8	7
Ms Marita Cowie	8	8

During the financial year, 1 meeting of the Audit Committee was held, with attendance as follows:

AUDIT MEMBERS	Audit Meetings	
	Eligible to attend	Attended
Dr Bruce Chater	1	1
Dr Jane Greacen	1	1
Dr Stephen Holmes	1	1
Dr Ruth Stewart	1	1
Ms Marita Cowie	1	1

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 this day of 2003.

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 2003 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 day of 2003.

STATEMENT OF FINANCIAL PERFORMANCE FOR THE YEAR ENDED 30 JUNE 2003

	Notes	2003 \$	2002 \$
Revenues from Ordinary Activities	2	6 215 748	3 175 683
Expenses from Ordinary Activities	3	(4 002 552)	(3 408 857)
Borrowing Costs Expenses		-	-
Surplus / (Deficit) from Ordinary Activities		2 213 196	(233 174)
Income Tax Expense		-	-
Net Surplus / (Deficit)		2 213 196	(233 174)

The above Statement of Financial Performance should be read in conjunction with the attached notes.

STATEMENT OF FINANCIAL POSITION AS AT 30 JUNE 2003

	Notes	2003 \$	2002 \$
CURRENT ASSETS			
Cash Assets	5	3 196 981	2 531 489
Receivables	6	2 087 205	235 965
Other Assets	7	32 309	3 393
TOTAL CURRENT ASSETS		5 316 495	2 770 847
NON-CURRENT ASSETS			
Intangible Assets	8	249 017	415 000
Property, Plant & Equipment	9	93 121	117 092
TOTAL NON-CURRENT ASSETS		342 138	532 092
TOTAL ASSETS		5 658 633	3 302 939
CURRENT LIABILITIES			
Payables	10	955 738	819 382
Provisions	11	57 187	49 438
TOTAL CURRENT LIABILITIES		1 012 925	868 820
NON CURRENT-LIABILITIES			
Payables	10	-	5 000
Provisions	11	3 393	-
TOTAL NON-CURRENT LIABILITIES		3 393	5 000
TOTAL LIABILITIES		1 016 318	873 820
NET ASSETS		4 642 315	2 429 119
EQUITY			
Retained Surpluses	12	4 642 315	2 429 119
TOTAL EQUITY		4 642 315	2 429 119

The above Statement of Financial Performance should be read in conjunction with the attached notes.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 30 JUNE 2003

	Notes	2003 \$	2002 \$
Cash Flows from Operating Activities			
Receipts from Members		1 630 656	1 867 872
Interest Received		122 630	102 762
Grants Received		3 382 483	2 106 884
Payments to Suppliers and Employees		(4 185 166)	(2 972 225)
GST Recovered/(Paid)		(268 511)	(61 187)
Net Cash from Operating Activities	19 (i)	<u>682 092</u>	<u>1 044 106</u>
Cash Flows from Investing Activities			
Payments for Intangibles		-	(498 000)
Payments for Property, Plant and Equipment		(16 600)	(91 238)
Proceeds from sale of Property, Plant and Equipment		-	12 161
Net Cash Used in Investing Activities		<u>(16 600)</u>	<u>(577 077)</u>
Net Increase in Cash held		665 492	467 029
	19 (ii)		
Cash at the Beginning of the Financial Year		<u>2 531 489</u>	<u>2 064 460</u>
Cash at the End of the Financial Year	19 (ii)	<u>3 196 981</u>	<u>2 531 489</u>

The above Statement of Cash Flows should be read in conjunction with the attached notes.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2003

1. SUMMARY OF ACCOUNTING POLICIES

The financial report constitutes a general purpose financial report which has 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.

Basis of Accounting

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 non-current 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

- Grants received are brought to account as revenue where:
 - (a) The company has control over the contribution;
 - (b) It is probable that the economic benefit comprising the contribution will flow to the company; and
 - (c) The amount of the contribution can be reliably measured.
- Interest Revenue is recognised on a time proportionate basis that takes into account the effective yield on the financial asset.

- (c) The amount of the contribution can be reliably measured.
- Interest Revenue is recognised on a time proportionate basis that takes into account the effective yield on the financial asset.
- 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 Aged Care amounting to \$2,069,050. This is equivalent to 99.13% of the total debtors balance.

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	2003	2002
	\$	\$
Operating Revenue		
Rendering of Services	737 973	920 803
Grant Income	5 325 741	2 106
Sponsorship	15 000	884
Sundry Income	14 404	30 000
		3 073
Non Operating Revenue		
Interest	122 630	
Proceeds from Disposal of Assets	-	102 762
		12 161
	<u>6 215 748</u>	<u>3 175 683</u>
3. EXPENSES FROM ORDINARY ACTIVITIES		
<i>Classification of Expenses by Function:</i>		
College Services & Admin Expenses	612 922	521 335
Publication & Communication Services	110 640	55 829
RRAPP Grant Expenses	802 247	725 863
Radiology Grant Expenses	46 422	14 974
ACRRM Joint Standards Framework Expenses	-	4 539
John Flynn Scholarship Scheme Grant Expenses	1 003 111	1 917
Rural Training Grant Expenses	180 643	329
Obstetric Ultrasound Grant Expenses	337	149 047
Medical Rural Bonded Scholarship Grant Expenses	8 294	-
Other Project Expenses		19 941
	<u>4 002 552</u>	<u>3 408 857</u>
4. SURPLUS/(DEFICIT) FROM ORDINARY ACTIVITIES		
<i>Surplus/(Deficit) from Ordinary Activities includes:</i>		
• Net (Gain)/ Loss from the sale of Plant & Equipment	-	(3 175)
• Net Expense resulting in movements in provisions:	40 571	28 556
- Depreciation	165 983	83 000
- Amortisation	-	104
- Bad and Doubtful Debts		
5. CASH		
Cash on Hand	100	100
Cash at Bank	544 154	343 653
Cash on Deposit	2 652 727	2 187 736
	<u>3 196 981</u>	<u>2 531 489</u>
6. RECEIVABLES		
GST Receivable	-	22 551
Trade Receivables	2 087 205	213 414
	<u>2 087 205</u>	<u>235 965</u>
7. OTHER ASSETS		
Prepayments	32	3 393
	<u>309</u>	

8. INTANGIBLE ASSETS

Website Development	498 000	498 000
Accumulated Amortisation	<u>(248 983)</u>	<u>(83 000)</u>
	<u>249 017</u>	<u>415 000</u>

9. PROPERTY, PLANT AND EQUIPMENT

Office Equipment	177 818	161 218
Accumulated Depreciation	<u>(84 697)</u>	<u>(44 126)</u>
	<u>93 121</u>	<u>117 092</u>

Movement Schedule

Opening Balance	117 092	63 396
Additions	16 600	91 238
Disposals at Written Down Value	-	8 986
Depreciation Expense	<u>40 571</u>	<u>28 556</u>
Closing Balance	<u>93 121</u>	<u>117 092</u>

10. PAYABLES**(i) Current**

Trade and Sundry Creditors	482 960	510 232
Unearned Income	385 756	233 400
Accruals	86 873	66 358
GST Clearing	149	9 393
	<u>955 738</u>	<u>819 383</u>

(ii) Non-Current

Loan – Rural Doctors Association NSW (unsecured)	-	5 000
	<u>-</u>	<u>5 000</u>

11. PROVISIONS**(i) Current**

Employee Benefits	57 187	49 438
	<u>57 187</u>	<u>49 438</u>

(ii) Non-Current

Employee Benefits	3 393	-
	<u>3 393</u>	<u>-</u>
Aggregate Employee Benefits	<u>65 862</u>	<u>53 183</u>

12. RETAINED SURPLUSES

Retained Surplus at the beginning of year	2 429 119	2 662 293
Net Surplus/(Deficit)	2 213 196	(233 174)
Retained Surpluses at the end of year	<u>4 642 315</u>	<u>2 429 119</u>

13. AUDITORS REMUNERATION

Audit and review of Financial Statements	4 500	4 000
Other Project Audit Services	4 070	2 000
	<u>8 570</u>	<u>6 000</u>

14. 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.

15. CORPORATE INFORMATION

Australian College of Rural and Remote Medicine Limited is an Australian Company whose principal activities were 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 467 Enoggera Road, Alderley, Queensland. There are 20 employees (2002: 17) at the end of the reporting period.

16. SEGMENTATION INFORMATION

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

17. ECONOMIC DEPENDANCY

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.

18. RELATED PARTY TRANSACTIONS

The directors of the company pay membership fees under normal terms and conditions. The names of persons who held office during the year are as follows:

2003	2002
Professor Ian Wronski	Professor Ian Wronski
Dr Alan Bruce Chater	Dr Alan Bruce Chater
Dr Jane Greacen	Dr Jane Greacen (appointed 17/11/01)
Dr Brian Bowring	Dr Brian Bowring
Dr Wynand Breytenbach (resigned 2/11/02)	Dr Wynand Breytenbach
Dr John Brown (resigned 2/11/02)	Dr John Brown
Dr Bruce Cameron	Dr Bruce Cameron (reappointed 17/11/01)
Dr David Campbell	Dr David Campbell (reappointed 17/11/01)
Dr Mark Foreman (appointed 2/11/02)	Dr Mahinda Samararatna (resigned 17/11/01)
Dr Stephen Holmes	Dr Stephen Holmes
Dr Daniel Pettersson (resigned 2/11/02)	Dr Daniel Pettersson
Dr Leslie Woollard (appointed 2/11/02 and resigned 13/4/03)	Dr David Wilkinson (resigned 17/11/01)
Dr John Heinrich (appointed 2/11/02)	Dr Frederic McConnel (resigned 7/4/02)
Professor Roger Strasser (resigned 4/8/02)	Professor Roger Strasser (appointed 17/11/01)
Professor John Murdoch (appointed 15/1/03)	Dr Caroline Hawkins (resigned 29/4/02)
Dr Ruth Stewart (appointed 2/11/02)	
Dr Ian Kamerman (appointed 1/6/03)	

19. NOTES TO THE STATEMENT OF CASH FLOWS

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

	2003	2002
	\$	\$
Surplus/(Deficit) from ordinary activities after income tax	2 213 196	(233 174)
Depreciation	40 571	28 556
Amortisation	165 983	83 000
Loss/ (Gain) on Disposal of Assets	-	(3 175)
(Increase)/ Decrease in Trade Debtors	(1 873 792)	605 476
(Increase)/ Decrease in Non-Trade Debtors	-	(21 451)
(Increase) / Decrease in Prepayments	(28 916)	(1 903)
Increase / (Decrease) in Unearned Income	152 356	155 430
Increase in Trade Creditors and Accruals	(185 586)	432 943
Increase in Provisions	11 142	19 617
GST Clearing	187 138	(21 123)
Net Cash Provided By Operating Activities	682 092	1 044 106

For the purposes of the Statement of Cash Flows, 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	544 154	343 653
Cash on Deposit	2 652 727	2 187 736
	<u>3 196 981</u>	<u>2 531 489</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 recognised when earned. The effective weighted interest rate for 30/6/2003 is 4.24% (2002: 4.30%)

INDEPENDENT AUDIT REPORT TO MEMBERS OF ACRRM LTD

Scope

The financial report and directors' responsibility

The financial report comprises the statement of financial position, statement of financial performance, statement of cash flows, accompanying notes to the financial statements, and the directors' declaration for Australian College of Rural and Remote Medicine Limited, for the year ended 30 June 2003.

The directors of the company are responsible for the preparation and true and fair presentation of the financial report in accordance with the Corporations Act 2001. This includes responsibility for the maintenance of adequate accounting records and internal controls that are designed to prevent and detect fraud and error, and for the accounting policies and accounting estimates inherent in the financial report.

Audit approach

We conducted an independent audit in order to express an opinion to the members of the company. Our audit was conducted in accordance with Australian Auditing Standards in order to provide reasonable assurance as to whether the financial report is free of material misstatement. The nature of an audit is influenced by factors such as the use of professional judgement, selective testing, the inherent limitations of internal control, and the availability of persuasive rather than conclusive evidence. Therefore, an audit cannot guarantee that all material misstatements have been detected.

We performed procedures to assess whether in all material respects the financial report presents fairly, in accordance with the Corporations Act 2001, including compliance with Accounting Standards and other mandatory financial reporting requirements in Australia, a view which is consistent with our understanding of the company's financial position, and of its performance as represented by the results of its operations and cash flows.

We formed our audit opinion on the basis of these procedures, which included:

- examining, on a test basis, information to provide evidence supporting the amounts and disclosures in the financial report, and
- assessing the appropriateness of the accounting policies and disclosures used and the reasonableness of significant accounting estimates made by the directors.

While we considered the effectiveness of management's internal controls over financial reporting when determining the nature and extent of our procedures, our audit was not designed to provide assurance on internal controls.

Independence

In conducting our audit, we followed applicable independence requirements of Australian professional ethical pronouncements and the Corporations Act 2001.

Audit opinion

In our opinion, the financial report of Australian College of Rural and Remote Medicine Limited is in accordance with:

- (a) The Corporations Act 2001, including:
 - (i) giving a true and fair view of the company's financial position as at 30 June 2003 and of its performance for the year ended on that date; and
 - (ii) complying with Accounting Standards in Australia and the Corporations Regulations 2001; and
- (c) other mandatory financial reporting requirements in Australia.

PKF
Brisbane Partnership

CG Bellamy
Partner

Dated at Brisbane the day of October, 2003.

DETAILED STATEMENT OF FINANCIAL PERFORMANCE FOR THE YEAR ENDED 30 JUNE 2003

	2003 \$	2002 \$
INCOME		
Subscriptions	524 965	536 373
FACRRM	4 800	6 038
Sponsorship	15 000	30 000
Interest	122 630	102 762
Rural Training Grant	681 748	1 368 000
RRAPP Grant	1 245 455	471 273
Radiology Grant	4 776	8 000
Obstetric Ultrasound Program Grant	130 527	257 283
Consulting Fees	60 659	149 984
Proceeds from Sale of Plant & Equipment	-	12 161
Sundry Income	14 404	7 001
Medical Rural Bonded Scholarship Income	58 522	-
RRMEO	147 549	226 909
John Flynn Scholarship Grant	3 204 713	-
TOTAL INCOME	6 215 748	3 175 683
Less EXPENDITURE		
Accounting & Audit Fee	4 200	5 062
ACRRM/RACGP Framework	-	4 539
Advertising & Subscriptions	3 032	2 517
Amortisation	165 983	83 000
AMC Costs	6 716	-
Bad Debts Expense	-	104
Bank Charges	9 002	7 274
Computer & Equipment Maintenance	1 310	1 759
Conference & Meeting	12 147	22 565
Corporate Memberships	2 347	2 803
Depreciation	40 572	28 556
Disposal of Plant & Equipment	-	8 986
Employee Benefits	2 246	369
Equipment	3 920	-
Honorarium (President)	5 000	5 000
Insurance	6 394	3 505
John Flynn Scholarship Program	1 237 936	-
Legal Fees	12 123	337
Member Services	28 805	55 829
Obstetrics Ultrasound Program	180 643	149 047
PHEC Expenses	8 294	10 955
Postage	12 992	5 245
Printing/Photocopying/Stationery	22 940	42 355
Professional Services	6 513	33 010
Radiology Program	46 422	14 974



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