



## Australian College of Rural and Remote Medicine



**Annual Report  
2007 - 2008**

**Recognising Rural and Remote Medicine**

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### **Disclaimer**

ACRRM's Annual Report is intended to provide a brief introductory overview of ACRRM for the financial year 2007 - 2008

AUSTRALIAN COLLEGE OF RURAL AND  
REMOTE MEDICINE LIMITED

A.C.N 078 081 848

**Annual Report**  
**2007- 2008**

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## I President's Report

This is the first of two years that I have been privileged to have represented our College as President. The professional standards for rural and remote medicine, which define our place in the health sector and the care of our communities, have been our driving vision. It is no coincidence that our current Board has carried on the vision and intent of the founding members of our College: *to provide safe and high quality health care to the people of rural and remote Australia*. As we have developed our programs, our vision is becoming a reality, but we are not there yet. There are still many steps to achieving our goals, and these seem to be ever moving in the current environment of workforce depletion and redefinition.

We are a relatively small-membership college and disadvantaged to some extent by our being relatively new players in the medical college landscape. We do, however, represent the truest sense of the generalist medical perspective with the broad range of knowledge and skills that are necessary to provide safe and effective health care for our communities. The gradual emergence of the "generalist perspective" as part of future health planning is becoming an internationally recognised answer to the questions about the direction health systems are taking.

In the Australian Primary Health Care Institute Stream Six project the ACRRM team undertook, the systematic review on rural generalism identified the loss of generalism across the board as a cause of depletion of rural health services, and with increasing technology, an additional stimulus for the blow out in health care costs. In meeting the needs of our communities, ACRRM must advocate against the flow towards metropolitan based specialisation and sub specialisation. Our college needs to reverse the loss of the core skills maintained by the body of generalist practitioners, be they GPs, generalist specialists, generalist nurses or other non-specialist health providers from rural Australia. To do this we need to seek the training places for our future workforce. This is difficult with significant opposition, passively and aggressively active in preventing access to appropriate places for such procedural training. ACRRM has made strategic alliances with State Health Departments that have insight into the positive effects of generalist training in meeting the health needs of their communities. This has been a win for the future of our rural and remote workforce but we do need protect it from the blocking action of those who see rural communities "raison d'être" as to simply supply the needs and be subjugated to the whims of metropolitan Australia. Many excuses for such blocking have and will be offered to justify their actions but essentially they are about turf, power and influence and have little evidence to back their obstinacy. I suspect the road will be a long one and there will be many a hard yard to push through.

In April I was invited to address the Annual Meeting of the Canadian Society of Rural Physicians by their President and our friend Michael Jong. There are many similarities, but also a number of differences between the rural doctors of Canada and Australia. Canada has some interesting perspectives that we can learn from. Their Family Practice has two streams in their training; one is community based, and the other emergency medicine. This may explain the ready acceptance of non-office based pathways as part of the broad church of Family/General Practice. What Canada lacks is any form of National Rural Health Strategy, which we in Australia now take for granted.



**"We do represent the truest sense of the generalist medical perspective with a broad range of knowledge and skills that are necessary to provide safe and effective health care for our communities. "**

**“There is an opportunity for ACRRM to establish its role in advocacy for safe health systems pertinent to the welfare of rural and remote Australia.”**

On the other side of the Tasman I recently visited a number of the rural NZ hospital and procedural doctors and their College in Wellington. Apart from the exceedingly beautiful environment that they are fortunate to live and practice in, their system is interesting and seems to me quite idiosyncratic but nonetheless effective. They share many of the problems with training and legitimacy that we do in Australia. The demise of rural obstetrics is one such shared issue and hopefully Australia can learn from the NZ experience. Our ongoing relationship with both countries makes sense in the current climate of rural health shortages. How we establish ongoing relationships between our rural cohorts is one of our next challenges. WONCA Rural and the WHO Network, Towards Unity for Health, have provided an international perspective for rural family practice and rural health education. I feel there is still a place for our three countries to establish closer ties outside of these other organisations.

The past twelve months has seen ACRRM working towards meeting its objectives in accomplishing its obligations to meet its AMC accreditation. The ACRRM assessment process had had a number of completions which has shown the legitimacy and validity of our examination process. In doing this it has shown, as with other ACRRM programs, the usual innovation, relevancy and sensitivity to the needs of our rural members. The assessment team deserves congratulations for their efforts in completing this difficult set of tasks.

The successful awarding of the contract for the expanded John Flynn Scholarship Scheme has been a result, I am sure, of the past effective management by ACRRM staff. The reversal of the reduction in PGPPP numbers has been a welcome change in governmental direction. The reduction in the numbers would have been a lasting impediment on the “pipeline” effect of all of the ACRRM programs. It has been a good result for a number of organisations lobbying the current government. However the management of PGPPP may not be reallocated to ACRRM and the RACGP and this also poses a risk to the eventual outcomes of the program.

The Australian health system is going through a period of significant change. National Registration poses a number of opportunities and threats to our profession and to rural health in particular. There is an opportunity for ACRRM to establish its role in advocacy for safe health systems pertinent to the welfare of rural and remote Australia. Whether governments will listen may be another matter, but with ACRRM and RDAA working together with other rural advocacy groups, there is hope. The risk to our organisations is that rural and remote health may become less of a political imperative in a climate of major national health need. The cessation of the old GP Reference Group, and its replacement with the United General Practice Alliance which includes ACRRM, will hopefully add a uniting voice to general practice/primary health care medicine. As a consensus group we seem to be able to agree on a range of issues, and be able to have a free ranging and robust discussion on the issues affecting our discipline.

The current ACRRM Board has provided our College with leadership and direction. They have represented the membership with strategic direction and honest intent. It is always difficult to have a board of governance whose members are overwhelmed with the day to day demands of an underserved workforce, the pressing needs of their communities, and manage to have a life

with their families. They have provided a strategic as well as day to day direction for our College and have supported and assisted the staff to identify risks and threats to our ongoing development and survival. I would like to thank them for their patience, sage advice, good humour and tolerance during the many teleconferences and meetings over the past twelve months. I would especially like to thank our Vice President, Ruth Stewart, for her increasing involvement in our national agenda, and our Censor Richard Murray, for his ongoing efforts in setting and enhancing the standards to which we operate.

Last but most definitely not the least, over the past eleven years, ACRRM has been fortunate to have employed a number of extremely hard working and dedicated people who have never stinted at meeting the heavy workloads, timelines and urgent responses to one crisis or another. Under the guidance of our CEO, Marita Cowie, ACRRM and its membership would never have been able to achieve a fraction of the outcomes in the timeframe that it has. I would like to thank them for their untiring support, commitment, and outstanding initiative which has made our College such a vibrant and stimulating organisation.



Associate Professor Dennis Pashen  
President

## I CEO's Report

I am very pleased to be presenting my 10th annual report as Chief Executive Officer for the College. It has been another busy and highly productive year. Significant achievements were milestones in delivery of the College's assessment program and the full implementation of vocational training pathways that offer attractive and real alternatives for general practice registrars.

Alongside the substantial activity that has occurred in standards, education and program design - which is outlined elsewhere in this report - the College also experienced some key staff changes. We have welcomed Janelle Walsh to the team in a new role as Business Services Manager. We have also farewelled two longstanding managers. Vicki Sheedy, who had been ACRRM's Education Manager for seven years, decided to take up a new national position with the National Aboriginal Community Controlled Health Organisation (NACCHO). Vicki's role has been filled by Ms Sara Harrup, who had previously been coordinating ACRRM's student support initiatives. Anna Nichols, who had worked with ACRRM for nine years, decided to retire this year. Recruitment is underway to fill Anna's position as Prevocational Training Manager. ACRRM has recognised Vicki and Anna and their enormous personal contribution to the College and the rural medical profession by awarding them Honorary Membership of ACRRM. Their leadership, talent and friendship will certainly be missed and I wish them both well in their new endeavours.

ACRRM has continued to develop and expand career and support options for rural doctors by increasing its range of innovative rural medicine programs. The College has collaborated closely with Queensland Health to implement the new Rural Generalist Medicine Training Program and signs are strong that other jurisdictions will also consider introducing this program. ACRRM has also partnered with RACGP and a range of other colleges and agencies to develop new courses, and has contributed to a number of key strategic collaborations within the sector.


Considerable energy has been spent working with GPET, regional training providers, registrars, junior doctors and students to increase awareness of the College and the training and assessment options it now provides. Despite the amount of change in general practice training over the past eight years, the introduction of the ACRRM vocational training program as a genuine alternative for achieving vocational recognition as a general practitioner, represents arguably the most significant change of all. The change management role that ACRRM must play to ensure successful implementation of the program is challenging. I expect the College will need to continue playing an active role in this for some time to come.

The College has also published an important research paper this year which provides a systematic review of "rural medical generalism" internationally. This initiative was funded through the Australian Primary Health Care Research Institute and provided a significant opportunity to examine the nature and importance of medical generalism in rural and remote health. It also provided an opportunity for significant dialogue with national policy makers in formal and informal formats. In coming years the College will continue to work hard to ensure that generalism and rural and remote practice are better understood and appreciated by key stakeholders, including government.



**"...the ACRRM vocational training program for achieving vocational recognition as a general practitioner, represents arguably the most significant change of all."**

Finally, I am confident that the year ahead will be just as busy and challenging for ACRRM as previous years. The College management and staff will continue to work with our members, colleagues and partners to deliver top quality programs, courses and services that meet our member's needs as well as those of the wider profession. ACRRM members continue to be a wonderful inspiration and powerhouse for ideas and motivation. They have always been generous in making themselves available for College work and representation, and this will continue to be crucial for the future success and relevance of our work.



Marita Cowie  
Chief Executive Office

## I Censor's Report

Assessment and promotion of the training program for Fellowship of ACRRM have been themes of the 2008 financial year.

All components of the College's assessment program were implemented across the country. This included the Learning Portfolio, Multisource Feedback, Mini Clinical Evaluation Exercise (MiniCEX), Core Competencies Procedural Logbook, Multiple Choice Examination and Structured Assessment using Multiple Patient Scenarios (StAMPS).

Over 100 candidates enrolled across four assessment modes. This included 22 candidates in the first Multiple Choice Examination and eight in the first StAMPS examination. In each case, the examination was held in the home community of the candidate. Five people completed the exam while living and working in the most remote regions of Australia and a number completed requirements from overseas locations.

Over the 2007-2008 financial year, 11 candidates were awarded Fellowship under the Vocational Preparation Pathway and two under the Independent Pathway.

Implementation of the Vocational Preparation Pathway through the Australian General Practice Training system and regional training providers has been the primary challenge. College vocational training staff undertook a road show to 19 of the 21 regional training providers across Australia to introduce, discuss and promote the ACRRM training program.

The scale of this task in the AGPT environment has been challenging. Nonetheless, the College experienced an encouraging willingness from providers to engage with and support the program.

My sincere thanks to all members of the Censorial Committee and subcommittees for generously giving their time and talent, and to all the College staff who have laboured tirelessly to achieve some historic outcomes for rural medicine.



Associate Professor Richard Murray  
Censor



**"... the College experienced an encouraging willingness from providers to engage with and support the program"**

## I Professional Development Program Report

The Professional Development Program (PDP) has seen significant expansion over the past twelve months, particularly in terms of program development and delivery, strategic planning, and review.

As the 2005-2007 triennium was concluding the PDP Committee took the opportunity to review the program. The program review ensures ACRRM continues to achieve world's best practice in providing professional development in the rural and remote context, and quality improvement important for ACRRM members. Following the review, new compliance requirements for the 2008-2010 triennium were introduced. While the requirement to accumulate 100 points remains, the areas for accumulation of these points has been extended. These are reflected in the revised points-allocation framework in which participants can undertake a range of educational activities more relevant to their practice requirements.

**"... PDP has continued to increase the choice and quality of accredited activities available to members"**

During the year, PDP has continued to increase the choice and quality of accredited activities available to members. ACRRM has worked with a number of providers to ensure the development and implementation of new educational opportunities, and has undertaken the development of a number of new innovative online modules and activities to address the identified needs of members.

### **PDP Participation**

As at 30 June 2008, there were 1684 participants registered in the ACRRM PDP program. Participants were ACRRM Fellows maintaining their Fellowship and VR requirements, and non-fellow members maintaining their VR requirements.

There were also increases in the number of ACRRM members requiring third-party reporting for Maintenance Of Professional Standards in most specialised disciplines. However, there was a decrease in the mental health component as the Commonwealth withdrew its requirement to report Level 1 mental health during the year.

### **Professional Development Activities**

The number of activities listed on ACRRM's educational inventory has steadily increased over the year. There was also an increase in the number of educational activities ACRRM developed during the period for its members. New activities included Dental Emergency and a Medical Acupuncture Peer Review Group.

The number of education providers seeking ACRRM accreditation also increased over the year to 536.

### **Committee**

Dr Helena Johnston has continued to chair the PDP Committee and oversee the activities of the Accreditation Sub-committee. PDP has continued to grow under her leadership and we would like to thank all members of the committee for their dedication and commitment over the past year.

## **Procedural Training Grants Program**

The College continued to build on its strength and leadership in procedural medicine as a manager of the Commonwealth Government's Training for Rural and Remote Procedural GPs program. ACRRM registered 1,417 doctors: 738 in the emergency medicine component of the program and 679 in the procedural medicine component.

## **Staff**

The PDP team provides a number of services to members at the post-vocational level and undertakes activities such as program and committee support for the PDP and Procedural Medicine program, policy development and implementation, accreditation, recording and reporting, educational resource development, and membership and provider support.

## I Assessment Program Report

The last year has seen the progressive roll-out of the College's Assessment Program to candidates working in locations throughout Australia.

The Assessment Program is a valid and reliable assessment of a candidate's knowledge, skills and attitudes. It reflects the educational outcomes of the ACRRM curriculum, and is relevant to the rural and remote context.

The Assessment Program offers a number of features that benefit candidates and ensure a high quality outcome.

- Assessment is delivered to each candidate in their home-town environment. This saves candidates travel and accommodation costs, and avoids the need for a locum.
- The program has a series of structured formative assessment steps that provide candidates with extensive personal feedback. Candidates can self-pace their learning and address any areas of relative weakness as these arise; and
- A variety of assessment components have been developed to measure the range of knowledge, skills, and attitudes essential to attaining a FACRRM. This ensures the depth and breadth of the curriculum is represented across the Assessment Program resulting in capable and confident doctors graduating as Fellows of the College.

**“...the assessment is delivered to each candidate in their home-town environment. This benefits candidates by avoiding travel and accommodation costs as well as the need for locum support”**

During 2007-2008, the assessment components outlined below have been developed and rolled out.

### **Learning Portfolio**

The Learning Portfolio is a formative learning aid. It is operational in nature and assists registrars and their teachers, supervisors and mentors to monitor and manage the content of the ACRRM primary curriculum.

### **Multi Source Feedback (MSF)**

This is a formative and summative tool. Currently in a pilot phase the MSF is to be formally rolled-out in February 2009. The MSF assesses each candidate's interpersonal and professional behaviour and development in their practice via a 360 Degree Appraisal Tool.

The examination consists of two key components:

- a) a colleague assessment tool; and
- b) a patient assessment tool.

### **Mini Clinical Assessment Exercise (miniCEX):**

The miniCEX is a practice-based assessment. It evaluates overall clinical competence in areas such as communication skills, history taking, physical examination, clinical judgment, clinical organisation, and efficiency.

### **Core Competencies Procedural Logbook**

The Procedural Logbook is a summative tool that provides an assessment of the registrar's key psychomotor procedural skills and details the level of competency required for independent rural and remote practice. The logbook contains procedural items that are defined as mandatory skills in the ACRRM Primary Curriculum.

**“... the examination has been held in the home community of the candidate in locations both in Australia and overseas, including 5 people completing the exam while living and working in the most remote regions of Australia.”**

### **Multiple Choice Examination**

This summative process provides an assessment of the candidate's recall, reasoning, and applied clinical knowledge. The assessment is conducted through a secure website with the candidate located in or near their home community.

### **Structured Assessment using Multiple Patient Scenarios (StAMPS)**

StAMPS is a summative process undertaken by videoconference. It assesses higher order functions in a highly contextualised framework. Candidates have the opportunity to explain what they do and provide an explanation of their clinical reasoning rather than just evidence of knowledge.

More than 100 candidates enrolled across four assessment modes, with 22 candidates in the inaugural Multiple Choice Examination and eight in the inaugural StAMPS examination. In each case, the examination has been held in the home community of the candidate in locations in Australia and overseas, including five people in the most remote regions of Australia.

All examiners and question writers are vocationally registered ACRRM Fellows and undergo specific training in formal programs such as the annual MCQ writer's workshop, and the biennial StAMPS examiner training and examination weekends.

## I Vocational Training Report

The Vocational Training Program trains and supports doctors to be safe, independent and confident generalist practitioners capable of working anywhere in Australia, including diverse rural and remote settings.

During 2007-2008, ACRRM implemented its Vocational Training Program for 227 registrars, a 68% increase from the previous year. Candidates were enrolled in both the Australian General Practice Training (AGPT) and the Remote Vocational Training Scheme (RVTS).

An extensive program to support both registrars and training providers was implemented by the Vocational Training team to:

- provide workshops for all training providers;
- offer one-on-one advice for registrars and training providers;
- conduct regular teleconferences with training providers; and
- communicate regularly with registrars and RTPs through eNewsletters, responses to frequently asked questions, and Fact Sheets.

**“During 2007-2008 ACRRM implemented its Vocational Training Program for 227 registrars, a 68% increase from the previous year”**

ACRRM also had 54 registrars enrolled in the Independent Pathway. New enrolments were not accepted during 2007-2008 while the College reviewed the pathway and its structures. The College plans to reopen this pathway in 2008-2009.

### **ACRRM Accreditation of teaching posts and practices**

As at 30 June 2008, 333 teaching posts and practices were accredited to provide registrar training for Fellowship of ACRRM (FACRRM). That represented an increase of 43% over the previous year.

Teaching posts and practices include:

- eligible aboriginal medical services;
- rural and metropolitan hospitals;
- rural general practices; and
- Royal Flying Doctor Service bases.

### **ACRRM accreditation of Regional Training Providers**

Regional Training Providers seeking ACRRM recognition for delivering FACRRM training were required to register with ACRRM, complete self assessment against ACRRM standards, and participate in the accreditation process managed by GPET.

As at 30 June 2008, 17 of the 21 Regional Training Providers contracted by GPET had achieved ACRRM accreditation. The remaining four are urban based providers who do not plan to deliver FACRRM training in the near future.

### **Queensland Rural Generalist Program**

ACRRM worked with Queensland Health to implement the Queensland Rural Generalist Program. This has included a program of activity for prevocational doctors, as well as integrating rural generalists into the existing AGPT and RVTS programs.

## I Prevocational Programs Report

### Prevocational General Practice Placements Program (PGPPP)

The Prevocational General Practice Placements Programs provide supervised placements for junior doctors in remote, rural, and small regional locations throughout Australia. The program is seen as an important link in the vertical integration of rural training between rural students and rural career pathways.

As at 30 June 2008, 388 interns and residents had undertaken a PGPPP placement through ACRRM. ACRRM and its regional partners established training places in more than 50 practices across all states and territories of Australia. Program staff worked with 36 training hospitals, which act as feeders to the program.

**“As at 30 June 2008, 388 interns and residents had undertaken a PGPPP placement.”**

The evaluation of outcomes has indicated that participants found the PGPPP to be very influential in their choice of career in rural and community based practice, and that the training provided was highly effective.

ACRRM promotes the program to junior doctors through:

- promotional materials and newsletters;
- key medical conferences;
- Rural Workforce Agency; and
- Rural Doctors Associations.

ACRRM continued to provide secretariat services for PGPPP and to act as the Managing Organisation for the rural and remote component of the program disbursing almost \$7.5M 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.

All junior doctors undertaking a PGPPP were surveyed at the completion of their placement. The analysis of the findings indicated that approximately 50% of the junior doctors would be interested in undertaking vocational training in either a rural or regional area. 67% of junior doctors had their existing interest in rural medicine 'confirmed' or reinforced by the placement.

In respect of future work locations, 80% of junior doctors indicated that they would be interested in working in either a regional or rural location.

In rating their clinical experience under PGPPP, 90% of junior doctors rated the program as highly effective in providing a sense of autonomy as a doctor, while 93% rated the program as highly effective in providing experience of a different spectrum of illness/injury seen in general practice as distinct from the teaching hospital setting.

**Figure 1. Junior Doctor Learning Criteria Survey Results 2007-2008**

Learning Criteria	Highly Effective	Effective	Less Effective
<b>Teaching/ Learning Environment</b>			
Knowledgeable and interested supervision	88%	9%	3%
<b>Clinical Experience</b>			
A sense of autonomy as a doctor	90%	7%	3%
A satisfactory level of medical and professional responsibility given to treat patients	94%	3%	3%
Attainment of a broad range of clinical skills in general practice	87%	10%	3%
Good 'hands on' experience	88%	10%	2%
Appropriate access to supervision and expert advice	86%	11%	3%
Experience of a different spectrum of illness/injury seen in general practice as distinct from the teaching hospital setting	93%	6%	1%
Capacity to practice continuity of care	86%	11%	3%
Treating people in context	90%	9%	1%
Appreciating the differences in access to specialists and other health professionals in the treatment of patients	91%	8%	1%
<b>Training Issues</b>			
Capacity for personal and professional growth in a different setting to the hospital	87%	11%	2%
<b>Work Environment</b>			
A satisfactory number of working hours required	88%	7%	5%
A fair working schedule in terms of length of sessions and frequency of time off	87%	9%	4%
Reasonable pace of work	85%	11%	4%

**“After successfully administering the JFPP for the past 6 years, ACCRM has again won the contract with the Department of Health and Ageing to continue facilitating the program for another four years.”**

**John Flynn Placements Program (JFPP)**

ACRRM has successfully managed and administered the John Flynn Placement Program (JFPP) since 2002. JFPP is an Australian Government initiative funded through the Department of Health and Ageing.

The JFPP facilitates medical students' exposure to rural practice and lifestyles. The program stems from research which shows students' positive experiences of rural practice and lifestyle significantly influence their decision to pursue a career in rural medicine.

ACRRM's commitment to a vertically integrated approach to education and training for rural practice is supported by the College's management of the JFPP.

The popularity of the program has increased significantly with a 22% increase in applications from the previous year to 640. Applicants were competing for 150 places in the program.

The total number of current students was 610, and the annual growth rate is 150 places per year. Over the year students undertook a total of 531 placements.

Following six years successfully administering the JFPP, ACRRM again won a competitive tender and was contracted by the Department of Health and Ageing to manage the program for a further four years. The Australian Government's commitment to doubling the number of participants in JFPP during the 2008 - 2012 contract period will be an exciting growth opportunity for the program.

Through its vibrant and committed management ACRRM has supported a program which inspires and impassions medical students to pursue a career in rural medicine and become extraordinary people in remarkable places.

### Medical Rural Bonded Support Scheme

ACRRM has been managing and administering the Medical Rural Bonded Support Scheme (MRB program) since June 2003. The program is funded by the Department of Health and Ageing and provides a suite of support services to enhance MRB Scholars' medical training experience.

These include:

- networking, information, and support;
- quarterly newsletters;
- access to a network of medical contacts;
- access to a conference program which enables scholars to attend national rural health oriented events (130 scholars attend 23 separate conferences);
- access to a virtual community for peer support (500 scholars registering over 15,000 hits);
- access to a database of training posts;
- access to educational events relevant to rural and remote practice; and
- a personalised learning planner.

Currently, there are 691 MRB participants; 504 are students and 187 graduated doctors at various stages through the education continuum. The growth rate for MRB support is an additional 100 students per year.

### Bonded Medical Placements Scheme

The Bonded Medical Placements (BMP) Scheme is a program designed to assist participants gain early exposure to issues relating to practising medicine in outer-metropolitan, regional, rural, and remote areas of Australia. The benefit of the program is that this exposure is gained while they are attending university and as postgraduate junior doctors. BMP is an Australian Government initiative funded through the Department of Health and Ageing.

Through the BMP program, ACRRM provides students with a range of support services designed to enhance their medical training experience.

These include:

- mentoring;
- quarterly newsletters;
- a dedicated website;
- access to online medical resources;
- access to a database of training posts;
- access to educational events relevant to rural and remote practice;
- a personalised learning planner;
- topic based eMentoring sessions e.g. Emergency Medicine; and
- opportunities for the scheme participants to attend conferences/events related to health issues in Districts of Workforce Shortage (148 students attended 12 separate conferences).

Since the BMP Support Scheme commenced in July 2007, the number of participants registered with the scheme has almost trebled: from 450 to 1,155.

The pilot will be fully evaluated in the coming financial year and feedback from the evaluation will be used to determine the requirements for an ongoing support package for BMP Scheme participants.

**“Through the MRB program ACRRM provides scholars with a range of support services designed to enhance their medical training experience”**



**“Since the BMP Support Scheme commenced in July 2007, the number of participants who have registered with the scheme has reflected strong growth; from 450 participants in July 2007 to a present cohort of 1155.”**

## I Online Services Report

ACRRM's Online Services unit continued to expand its level of services to ACRRM members with online education modules, discussion forums, and other education related activities hosted on ACRRM's Rural and Remote Medical Education Online (RRMEO) website.

### RRMEO

RRMEO had more than 10,000 registered users. Almost all of ACRRM's 2,500 members used the online learning planner and record-keeping systems to maintain their training records for vocational training, professional development, and other reporting requirements. During 2007-2008 the number of site visits increased by 35% (from 69,053 to 106,685).

The improved RRMEO interface ([www.rrmeo.com](http://www.rrmeo.com)) launched last year has been well accepted by regular users, and a plan for continuous improvement was instigated.

Over the year, improvements included:

- a rebuild of the Educational Inventory which resulted in a simplified interface with greater functionality. Further improvements to the Educational Inventory were commenced;
- an upgrade of the PDA Clinical Guidelines was released. The new version contained additional content and updates, and two new disciplines: Radiology Tips for Rural Doctors and Rheumatic Heart Disease Guides (from the Heart Foundation of Australia); and
- the ACRRM Multiple Choice Questionnaire (MCQ) assessment process was established on RRMEO and launched in March 2008.

During the year ACRRM partnered with Medicare Australia to develop an online module to introduce the Australian Medicare System. An extensive range of other online courses were also developed or updated during the year (e.g. a set of 12 'Quality Use of Medicine' modules).

ACRRM's involvement in the Rural Generalist Project has resulted in a stronger relationship with Queensland Health. Through this relationship, RRMEO access has now been extended to include PGY1 interns at a number of hospitals throughout the state. It is anticipated that this will roll out to a broader range of interns over the next 12 months. Queensland Health currently has over 500 users on RRMEO.

There were significant increases in the numbers of practitioners using the popular Tele-Medicine Programs. Tele-Derm had a 17% increase in usage (from 1253 to 1518 participants). Radiology Online had a 25% increase (from 797 to 1058 participants).

During the year the Australian Government Department of Health and Ageing's Medical Specialist Outreach Assistance Program (MSOAP) extended its support by providing increased access to the Tele-medicine programs to all doctors living in MSOAP-funded areas of Australia. An additional 121 doctors now access the online programs through this support.

### ACRRM Website

Online services began researching tools and techniques that could be used to update the ACRRM website. It is anticipated that ACRRM will use online tools such as online forms, blogs, and RSS feeds to enhance and streamline its online information.

**“RRMEO now has more than 10,000 registered users, with nearly all of ACRRM's 2,500 members using the online learning planner.”**



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**FINANCIAL STATEMENTS**  
**FOR THE YEAR ENDED 30 JUNE 2008**

## I Director's Report

The Directors submit the following report for the year ended 30 June 2008 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 (resigned 27 October 2007)*  
*Associate Professor Dennis Pashen*  
*Dr Patrick Giddings*  
*Dr Neil Beaton (resigned 27 October 2007)*  
*Associate Professor Ruth Stewart*  
*Dr Kris Bascomb*  
*Associate Professor Elizabeth Chalmers*  
*Dr Louis Peachey (resigned 27 October 2007)*  
*Dr Aniello Iannuzzi*  
*Dr Jennifer Delima*  
*Professor John (Campbell) Murdoch (resigned 6 November 2007)*  
*Dr Scott Lewis (resigned 27 October 2007)*  
*Dr Louise Stone*  
*Dr Nola Maxfield*  
*Dr Jonathan Outridge (appointed 27 October 2007)*  
*Dr Michael Eaton (appointed 14 January 2008)*  
*Dr John Russell (appointed 22 January 2008)*  
*Dr John Robson (appointed 3 March 2008)*  
*Dr Jeffrey Ayton (appointed 14 March 2008)*

### Principal Activities

The principal activity of the Company during the year ended 30 June 2008 was the provision of medical education and training services to doctors.

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

### Review and Results of Operations

The deficit from ordinary activities for the year ended 30 June 2008 amounted to \$223,953 (2007 surplus: \$100,562). This deficit is made up of a College surplus of \$145,478 and a project loss of \$369,431.

The project loss of \$369,431 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 anticipates a continuation in 2008-2009 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.

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 on Directors**

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

#### **Dr David Campbell (resigned 27 October 2007)**

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 25 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, 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. Family Med

Dr Pat Giddings was elected Treasurer of ACRRM on 29 October 2005. He is the Chief Executive Officer of the Remote Vocational Training Scheme (RVTS) program. He is based in Albury-Wodonga.

#### **Dr Neil Beaton (resigned 27 October 2007)**

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.

#### **Associate Professor Ruth Stewart**

MBBS, DRANZCOG, FACRRM

Associate Professor Ruth Stewart was elected Vice President in November 2007, having served as the Victorian Director on the ACRRM Board from 19 November 2006. A/Prof Stewart was previously the Women in Rural Practice (WIRP) Director on the ACRRM Board from 2002-2006. She serves on the board of the Greater Green Triangle General Practice Education and Training and represents ACRRM on a number of other external committees including the National Evidence Based Antenatal Guideline Expert Advisory Committee. She is Director of Clinical Studies,:

Parallel Rural Community Curriculum with the Deakin University School of Medicine.

**Dr Kris Bascomb**  
MBBS

Dr Kris Bascomb was appointed South Australian Director on the ACRRM Board on 19 November 2006. Kris was previously the Registrar Director on the ACRRM Board. Dr Bascomb is currently a rural registrar with Adelaide to Outback, and with a strong interest and experience in surgery and O&G.

**Associate Professor Elizabeth Chalmers**  
MBChB, MPH, FAFPHM, FACHAM, FACRRM

Associate Professor Elizabeth Chalmers is currently the Academic Director on the ACRRM Board. She is the college nominee to Board of General Practice Education and Training (GPET) and is the Chair of the Northern Territory Post Graduate Medical Education Council. Associate Professor Chalmers represents ACRRM on the Editorial Board of the Australian Journal of Rural Health (AJRH).

**Dr Louis Peachey (resigned 27 October 2007)**  
B.Med (University of Newcastle upon Hunter), FACRRM

Dr Louis Peachey is 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 Aniello Iannuzzi**  
BA, MBBS, MMed Sci, FACRRM, FRACGP

Dr Aniello Iannuzzi was appointed the New South Wales Director on the ACRRM Board on 19 November 2006. He is a rural practitioner in private practice at the Warrumbungle Medical Centre, Coonabarabran, and also a VMO at the Coonabarabran District Hospital. Since 1998, he has been an AMA (NSW) Branch Councillor. He is an Adjunct Senior Lecturer, Department of General Practice, University of Sydney.

**Dr Jennifer Delima**  
MBBS, MHA, AFCHSE, FACRRM, FRACGP

Dr Jennifer Delima was appointed the Northern Territory Director on the ACRRM Board on 19 November 2006. She has extensive experience in remote communities in Central Australia and the Top End, as well as Alice Springs. As a former Senior District Medical Officer she has been involved with hospital and community based health, aero medical retrieval, emergency medicine, paediatrics and indigenous general practice.

**Professor John (Campbell) Murdoch (resigned 6 November 2007)**  
MD PhD FRCGP, FRNZCGP, FACRRM

Professor John Murdoch was appointed the Western Australian Director on

School of Primary, Aboriginal and Rural Health Care of UWA. He has been actively involved in academic general practice and rural medical education for more than 30 years.

**Dr Scott Lewis (resigned 27 October 2007)**  
MBBS, DRANZCOG

Dr Scott Lewis was appointed the Registrar Director on the ACRRM Board on 19 November 2006. As well as his studies in medicine, and obstetrics through RANZCOG, he has completed studies in Early Management of Severe Trauma and Advanced Paediatric Life Support. He is a GP Registrar working half time in private practice in Quorn, South Australia and half time for the Royal Flying Doctor Service in Port Augusta.

**Meetings Of Directors**

During the 2007-2008 financial year, 7 meetings of directors were held, with attendance as follows

Directors	Directors Meetings	
	Eligible to attend	Attended
Dr David Campbell (resigned 27 October 2007)	2	2
Associate Professor Dennis Pashen	7	6
Dr Patrick Giddings	7	6
Dr Neil Beaton (resigned 27 October 2007)	2	1
Associate Professor Ruth Stewart	7	6
Dr Kris Bascomb	7	3
Associate Professor Elizabeth Chalmers	7	3
Dr Louis Peachey (resigned 27 October 2007)	2	0
Dr Aniello Iannuzzi	7	4
Dr Jennifer Delima	7	6
Professor John (Campbell) Murdoch (resigned 6 Nov 2007)	2	1
Dr Scott Lewis (resigned 27 October 2007)	2	0
Dr Louise Stone	7	5
Dr Nola Maxfield	7	3
Dr Jonathon Outridge (appointed 27 October 2007)	6	6
Dr Michael Eaton (appointed 14 January 2008)	4	4
Dr John Russell (appointed 22 January 2008)	4	2
Dr John Robson (appointed 3 March 2008)	4	4
Dr Jeffrey Ayton (appointed 14 March 2008)	4	4

**Attendance Of Ex Officio Board Members At Meetings Of Directors**

Ex Officio Members	Directors Meetings	
	Eligible to attend	Attended
Dr David Campbell, Immediate Past President	5	4
Dr Tom Doolan, Hon. Director of Education	7	5
Associate Professor Richard Murray, Censor	7	4
Dr Bruce Chater, Immediate Past President	2	2
Ms Marita Cowie, Chief Executive Officer	7	7

There is one formally constituted committee of the Board being the Executive Committee. During the financial year, 7 meetings of the Executive Committee were held, with attendance as follows:

Executive Members	Executive Meetings	
	Eligible to Attend	Attended
Dr David Campbell, President	2	2
Associate Professor Dennis Pashen, Vice President/President	7	7
Dr Patrick Giddings, Treasurer	7	7
Associate Professor Ruth Stewart, Victorian Director/Vice President	7	6
Ms Marita Cowie, Chief Executive Officer	7	7

The Finance Committee during the financial year had 5 meetings, with attendance as follows:

Finance Committee Members	Finance Committee Meetings	
	Eligible to attend	Attended
Dr Patrick Giddings, Treasurer, Chair	5	5
Associate Professor Ruth Stewart (Executive Member)	5	3
Dr Aniello Iannuzzi (Non-executive Member)	5	5
Dr Jonathon Outridge (Non-executive Member)	3	2
Dr Michael Eaton (Non-executive Member)	1	0
Dr Kris Bascomb (Non-executive Member)	1	0
Ms Marita Cowie, Chief Executive Officer (Ex-Officio Member)	5	4

### 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 on behalf of the company

Signed in accordance with a resolution of the Board of Directors



Director

Dated at Albury this 23<sup>rd</sup> Day of September 2008

**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 2008 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  
Brisbane Partnership  
Chartered Accountants

*R J Forbes*

R J Forbes

Dated at Brisbane this 23<sup>rd</sup> Day of September 2008

**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 2008 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.

*As Lockhart*

Director

Dated at Albury this 23<sup>rd</sup> Day of September 2008

**Statement of Financial Performance  
For the Year Ended 30 June 2008**

	Notes	2008 \$	2007 \$
Revenues from Ordinary Activities	2	13,965,735	11,967,731
Expenses from Ordinary Activities	3	(14,189,688)	(11,867,169)
Surplus/(Deficit) from Ordinary Activities		(223,953)	100,562
Income Tax Expense		-	
Net Surplus/(Deficit)		(223,953)	100,562

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

**Balance Sheet  
As at 30 June 2008**

	Notes	2008 \$	2007 \$
<b>CURRENT ASSETS</b>			
Cash and Cash Equivalents	5	7,781,770	11,233,974
Trade and Other Receivables	6	3,590,827	3,103,354
Other Assets	7	183,560	946,599
TOTAL CURRENT ASSETS		11,556,157	15,283,927
<b>NON-CURRENT ASSETS</b>			
Intangible Assets	8	87,705	131,551
Plant and Equipment	9	129,246	138,885
TOTAL NON-CURRENT ASSETS		216,951	270,436
TOTAL ASSETS		11,773,108	15,554,363
<b>CURRENT LIABILITIES</b>			
Trade and Other Payables	10	8,661,267	12,155,492
TOTAL CURRENT LIABILITIES		8,661,267	12,155,492
<b>NON-CURRENT LIABILITIES</b>			
Long-term Provisions	11	96,767	159,844
TOTAL NON-CURRENT LIABILITIES		96,767	159,844
TOTAL LIABILITIES		8,758,034	12,315,336
<b>NET ASSETS</b>		<b>3,015,074</b>	<b>3,239,027</b>
<b>EQUITY</b>			
Retained Earnings	12	3,015,074	3,239,027
<b>TOTAL EQUITY</b>		<b>3,015,074</b>	<b>3,239,027</b>

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

**Cash Flow Statement**  
**As at 30 June 2008**

	Notes	2008 \$	2007 \$
<b>Cash Flows from Operating Activities</b>			
Receipts from Members & Other Consultancies		2,052,933	1,944,498
Interest Received		210,187	640,641
Grants Received		7,577,421	8,889,357
Payments to Suppliers and Employees		(13,323,377)	(11,766,844)
GST Recovered/(Paid)		75,040	(222,170)
<b>Net Cash from Operating Activities</b>	20(i)	<u>(3,407,796)</u>	<u>(514,518)</u>
<b>Cash Flows from Investing Activities</b>			
Payments for Intangibles		-	-
Payments for Property, Plant and Equipment		(44,408)	(49,463)
<b>Net Cash Used in Investing Activities</b>		<u>(44,408)</u>	<u>(49,463)</u>
Net Increase (Decrease) in Cash held		(3,452,204)	(563,981)
Cash at the Beginning of the Financial Year		11,233,974	11,797,955
<b>Cash at the End of the Financial Year</b>	20(ii)	<u>7,781,770</u>	<u>11,233,974</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 Australian Accounting Standards other authoritative pronouncements of the Australian Accounting Standards Boards, Australian Accounting Interpretations 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.

A statement of compliance with International Financial Reporting Standards cannot be made due to the Company applying the not-for-profit sector specific requirements contained in the 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 non-current assets and their impact on operating results.

The accounting policies below have been consistently applied to all years presented.

**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 recognised in accordance with AASB 1004 Contributions and consequently are brought to account as revenue where:

- The company has control over the contribution;
- The 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.

Further, grant revenue is apportioned to match the expenses incurred in the project. Consequently, the unexpended portion of grant revenue is recognised as unearned income and is deferred to future periods while any overspend will be recognised early as a receivable.

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

(c) Subscriptions are recognised on an accrual basis proportionate to when the service is provided.

#### **Employee Benefits**

The following liabilities arising in respect of employee entitlements are measured at the amount expected to be paid when the liability is settled:

- wages and salaries, annual leave and sick leave regardless whether they are expected to be settled within twelve months of balance date.
- other employee entitlements which are expected to be settled within twelve months of balance date.

Long service leave liabilities are determined after taking into consideration years of service, current level of wages and salaries and past experience regarding staff departures.

#### **Leases**

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

#### **Intangible Assets**

The cost of creating a website has been capitalised under the conditions set out in Australian Accounting Interpretations. 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.

#### **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.

	2008 \$	2007 \$
Operating Revenue		
Rendering of Services	1,774,955	2,213,020
Grant Income	11,952,216	9,489,565
Sponsorship	23,909	59,112
Sundry Income	4,468	4,451
Non Operating Revenue		
Interest	210,187	201,583
	<u>13,965,735</u>	<u>11,967,731</u>
	2.	Revenues From Ordinary Activities

### 3 Expenses From Ordinary Activities

#### *Classification of Expenses by Function:*

College Services & Admin Expenses	1,827,873	1,290,741
Publication & Communication Services	40,141	33,471
Professional Development Program Grant Expenses	-	852,975
John Flynn Scholarship Scheme Grant Expenses	2,196,864	2,373,737
Obstetric Ultrasound Grant Expenses	-	57,813
Medical Rural Bonded Scholarship Grant Expenses	507,077	449,644
GP Procedural Grant Expenses	240,589	249,974
OTD Supervisors Grant Expenses	162,375	341,109
SEAC Grant Expenses	-	851,844
PGPPP Grant Expenses	7,960,004	5,365,841
MTRP Grant Expenses	96,691	-
Non – VR Assessment Grant Expenses	240,518	-
MSOAP Grant Expenses	325,001	-
BMPS Grant Expenses	592,525	20
	<u>14,189,658</u>	<u>11,867,169</u>

#### *Other Expenses*

Employee Benefits Expense	933,242	488,518
Amortisation and Depreciation Expense	94,503	108,639

### 4. Surplus/(Deficit) From Ordinary Activities

#### *Surplus/(Deficit) from Ordinary Activities includes:*

Net (Gain)/Loss from sale of Plant and Equipment	3,390	1,220
Net Expense resulting in movements in provisions:		
Depreciation	50,657	42,872
Amortisation	43,846	65,767
Rental expense from operating leases	197,000	89,611

### 5. Cash And Cash Equivalents

Cash on Hand	100	100
Cash at Bank	5,031,190	2,835,038
Cash on Deposit	2,750,480	8,398,836
	<u>7,781,770</u>	<u>11,233,974</u>

**6 Trade And Other Receivables**

	2008 \$	2007 \$
Trade Receivable	3,590,827	3,103,354
	<u>3,590,827</u>	<u>3,103,354</u>

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

Directors (other than loans to directors)	-	-
	<u>-</u>	<u>-</u>

**7. Other Assets**

Prepayments	183,560	946,599
	<u>183,560</u>	<u>946,599</u>

**8. Intangible Assets**

Website Development (at cost)	699,363	699,363
Accumulated Amortisation	(611,658)	(567,812)
	<u>87,705</u>	<u>131,551</u>

**9. Plant and Equipment**

Office Equipment (at cost)	385,635	368,494
Accumulated Depreciation	(256,389)	(229,609)
	<u>129,246</u>	<u>138,885</u>

**Movement Schedule**

Opening Balance	138,885	133,514
Additions	44,408	49,463
Disposals at Written Down Value	(3,390)	(1,220)
Depreciation Expense	(50,657)	(42,872)
Closing Balance	<u>129,246</u>	<u>138,885</u>

**10. Trade and Other Payables**

(i) Current		
Trade and Sundry Creditors	904,278	887,398
Unearned Income	6,551,123	10,138,845
Accruals	720,621	732,507
Employee Benefits	125,065	124,819
GST Payable	299,413	271,923
Long service leave	60,767	-
	<u>8,661,267</u>	<u>12,155,492</u>
Included in unearned income, are amounts from directors	4,755	6,908
	<u>4,755</u>	<u>6,908</u>

**11. Provisions**

Non-Current		
Employee Benefits	8,117	71,194
Provision for "Make Good"	88,650	88,650
	<u>96,767</u>	<u>159,844</u>

As retained earnings is the only equity of the Company, a Statement of Changes in Equity has not been included in these financial statements.

	2008 \$	2007 \$
Retained Earnings at the beginning of year	3,239,027	3,138,465
Net Surplus/(Deficit)	(223,953)	100,562
Retained Earnings at the end of year	<u>3,015,074</u>	<u>3,239,027</u>

### 13. Auditor's Remuneration

Audit and review of Financial Statements	6,500	5,000
Other Project Audit Services	6,600	6,200
	<u>13,100</u>	<u>11,200</u>

### 14. Commitments For Expenditure

Non-cancellable operating lease for lease of premises		
Commitments not provided for:		
No later than 1 year	206,850	197,000
Later than 1 year but no later than 5 years	684,700	891,549
	<u>91,550</u>	<u>1, 8088,549</u>
Licence fee for intellectual property (RRMEO)	-	135,000
Commitments not provided for:		
No later than 1 year	-	135,000
Later than 1 year but no later than 5 year		
	<u>891,550</u>	<u>1,223,549</u>

### 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. 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 36 employees (2007: 35) 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:

### 2008 & 2007

Dr David Campbell (resigned 27/10/07)	Dr David Campbell
A/ Professor Dennis Pashen	A/Professor Dennis Pashen
Dr Patrick Giddings	Dr Patrick Giddings
Dr Neil Beaton (resigned 27/10/07)	Dr Stephen Holmes (resigned 19/11/06)
A/Professor Ruth Stewart	Dr Neil Beaton
Dr Kris Bascomb	A/Professor Ruth Stewart
A/Professor Elizabeth Chalmers	Dr Ian Kamerman (resigned 19/11/06)
Dr Louis Peachey (resigned 27/10/07)	Dr John Togno (resigned 19/11/06)
Dr Aniello Iannuzzi	Dr Megan Rathbone (resigned 19/11/06)
Dr Jennifer Delima	Dr Kris Bascomb
Dr John (Campbell) Murdoch (resigned 6/11/07)	Dr Peter Rischbieth (resigned 13/02/07)
Dr Scott Lewis (resigned 27/10/07)	A/Professor Elizabeth Chalmers
Dr Louise Stone	Dr Robert Seton (resigned 19/11/06)
Dr Nola Maxfield	Dr Louis Peachey
Dr Jonathan Outridge (appointed 27/10/07)	Dr Jennifer Delima (appointed 19/11/06)
Dr Michael Eaton (appointed 14/01/08)	Dr Aniello Iannuzzi (appointed 19/11/06)
Dr John Russell (appointed 22/01/08)	Dr Louise Stone (appointed 19/11/06)
Dr John Robson (appointed 3/03/08)	Dr Nola Maxfield (appointed 13/02/07)
Dr Jeffrey Ayton (appointed 14/03/08)	Dr Scott Lewis (appointed 19/11/06)
	Dr John (Campbell) Murdoch (appointed 19/11/06)

## 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

	2008	2007
	\$	\$
Surplus/(Deficit) from ordinary activities after income tax	(223,953)	100,562
Depreciation	50,657	42,872
Amortisation	43,846	65,767
Loss/(Gain) on Disposal of Assets	3,390	1,220
(Increase)/Decrease in Trade Debtors	(491,248)	(1,346,117)
(Increase)/Decrease in Non-Trade Debtors	-	-
(Increase)/Decrease in Prepayments	763,039	(858,503)
Increase/(Decrease) in Unearned Income	(3,587,721)	852,883
Increase in Trade Creditors and Accruals	8,768	710,737
Increase/(Decrease) in Provisions	(2,064)	(12,915)
GST Clearing	27,490	(71,024)
Net Cash Provided by Operating Activities	(3,407,796)	(514,518)

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	5,031,190	2,835,038
Cash on Deposit	2,750,480	8,398,836
	7,781,770	11,233,974

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.

**21 Events After The Balance Sheet Date**

The financial report was authorised for issue on 23 September 2008 by the board of directors.

**22. Financial Instruments**

**Financial Risk Management Policies**

The Company's financial instruments consist mainly of deposits with the banks, accounts receivable and accounts payable.

The Company does not have any derivative instruments at 30 June 2008.

i) Treasury Risk Management

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

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

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

ii) Financial Risk Exposures and Management

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

Interest rate risk

As the company is funded mainly through government grants, the Company does not require loans and consequently is not exposed to interest rate risk.

No assets or liabilities of the company bear interest except for cash and cash equivalents. The interest rate (market) risk regarding these assets is monitored by the directors to ensure the best possible financial returns. At 30 June 2008 the weighted average effective interest rate in relation to cash and cash equivalents was 4.6% (2007 – 4.2%) with the interest rate being entirely represented by floating rates. In terms of interest rate sensitivity analysis, a 2% increase/decrease in interest rates would cause the net profit before tax and equity of the company to increase/decrease by \$155,000 annually assuming all other variables remain constant.

Foreign currency risk

The company is not exposed to fluctuations in foreign currencies.

Liquidity risk

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

Credit Risk

The maximum exposure to credit risk, excluding the value of any collateral or other security, at balance date to recognized financial assets, is the carrying amount, net of any provisions for impairment of those assets, as

disclosed in the balance sheet and notes to the financial statements.

There are no amounts of collateral held as security at 30 June 2008.

Credit risk arises from exposures to customers as well as deposits with financial institutions. The Company is not exposed to any significant credit risk because it does not trade, and its receivables are from providers of grant funding. Consequently, the finance committee does not monitor credit risk.

Whilst 94% of the total debtors are concentrated in one debtor, being the Department of Health and Ageing, the company considers credit risk to be negligible.





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