Australian Medical Association (South Australia) Inc.

AMA
SOUTH AUSTRALIA

Annual Report 2013

AMA(SA) Council

Membership of Council January – December 2013

Position on Council	
President	Dr Peter Sharley – to May 2013 (8)
	Dr Patricia Montanaro – from June 2013 (9)
Vice President	Dr Patricia Montanaro – to May 2013 (9)
	Dr Janice Fletcher – from June 2013 (6)
Immediate Past President	Dr Peter Sharley – from June 2013 (8)
Co-Chairs	Dr David Walsh (6)
	Dr Janice Fletcher (6)
Federal Councillors	
Branch Nominee	Dr Peter Sharley (8)
Area Representative for SA and NT	Dr Andrew Lavender – to May 2013 (2)
	Dr Patricia Montanaro – from June 2013 (9)
Treasurer	Dr Peter Ford – to May 2013 (3)
Craft Group Representatives	
Anaesthetists	Dr Margaret Cowling (8)
Emergency Medicine	Dr Conrad Williams – to March 2013 (0)
	Dr Hendrika Meyer – from May 2013 (5)
General Practitioners	Dr Christopher Clohesy (6)
Obstetricians and Gynaecologists	Dr Stephen Lane (6)
Pathologists	Dr Janice Fletcher – to May 2013 (6)
	Dr Heather Cain – from June 2013 (3)
Physicians	Dr Andrew Russell – to May 2013 (8)
	Dr William Tam – from June 2013 (9)
Psychiatrists	Dr Michelle Atchison (7)
Radiologists	Dr Andrew Wicks – to May 2013 (2)
	Dr Nicholas Rice – from June 2013 (4)
Surgeons	Dr David Walsh (6)
Paediatricians	Dr Andrew Kelly – from June 2013 (4)
Doctors in Training Representatives	Dr Andrew Shepherd (3)
Medical Students' Representatives	
Adelaide	Mr Shane Selvanderan (6)
Flinders	Mr John Floridis (6)
Ordinary Members of Council	Dr Christopher Moy (7)
	Dr Rahul Solanki (5)
	Dr Penelope Briscoe – to September 2013 (3)
	Dr Susan Baillie (6)
	Dr Stephan Van Eeden (3)
	Dr Roger Sexton (6)
	Dr Penelope Briscoe – to December 2013 (3)
	Dr William Tam – to May 2013 (9)
	Dr Peter Ford – from August 2013 (3)
	Dr Emma Rischbieth – from April 2013 (3)
Regional Representatives	
Northern	Dr John Williams (7)
	Dr Nigel Stewart (1)
Southern	Dr Oluwadare Kuku (3)
	Dr Peter Tait (2)
Salaried Medical Officers' Representative	Casual Vacancy – to May 2013
	Dr Andrew Russell – from June 2013 (8)

Note: Numbers indicate attendance at the AMA(SA) Council meetings February - December 2013 (a total of 9 meetings) and include attendance both in person and by teleconference. Following the AGM some Councillors have attended in a different role.

Dr Patricia Montanaro
President, AMA(SA)

From the President

The year of 2013 was another busy one for the AMA (South Australia). We continue to build on the good work that has already been done, but with an eye to where the AMA wants to be in the future, and how we bring more of our colleagues into the fold. We are continuing to strengthen our connections with other medical organizations, acting as a resource, a strong ally and a solution broker.

Our advocacy continues to be as broad as our membership. Some of it you read about in our publications or the mainstream or specialist press, some you hear from your colleagues, or experience directly, and some remains largely unspoken, but its effects can be seen in improved government policies and responses, legislation, and attention to the issues that matter. Many members are assisted by the AMA each year, with practice or more personal matters, and these quiet services often remain known only to those involved, but long appreciated and remembered by those heard and helped by their (your) representative body.

As the organization that represents the gamut of medical practice, we can and do play an important role in bringing different views, perspectives and expertise together to find consensus and solutions. When we make our case to government, to politicians and to other stakeholders, it is a case informed by a big picture view that encompasses all the strengths of highly specialized knowledge, along with the broader perspective that considers how this fits within the whole.

AMA(SA) Council

We could not achieve what we do without the commitment and expertise of our state Council, the members of which give generously of their time to help inform and guide the Association's work. I must pay especial thanks here to Dr Peter Sharley, from whom I took over as state president in May 2013, and who continues to provide a valued voice and expertise. I must also express my thanks and appreciation for Dr Janice Fletcher's invaluable support as AMA(SA) Vice President. It is perhaps also worth noting that this is the first time in the Association's history in which there has been an all-female President and Vice-President team.

I would also like to pay special tribute to another colleague, Dr Andrew Lavender, who in 2013 retired from our state and federal Councils after many years of hard and important work on behalf of the profession. Andrew joined our state Council in 2001 and federal Council in 2008, and as president from 2009-11 he guided us through a complex and challenging time. Few know the full extent of the work he has put in but it has been of great value, over a long period.

A great sadness to the Council in 2013, and the SA health and medical community, was the death of Councillor Dr Conrad Williams from cancer on 30 March, 2013, aged 42. Conrad had served on our State Council since 2009, first as the representative for Salaried Medical Officers and then as the craft group representative for Emergency Medicine. His energy, passion and commitment were outstanding and his contributions to the AMA were significant and highly valued, and reflected his broader contributions in the health community, and as a doctor.

The Council is supported by a number of specialist committees (Road Safety; General Practice; Historical; Doctors in Training; and Communications) and the Association's operations are guided now by our new Executive Board. AMA(SA) CEO Joe Hooper ably leads and has generated much change in what is an exciting and challenging time for the AMA(SA) as the Association seeks to broaden its vision and service to the profession. He and the Council are supported by a great staff team, who have our great appreciation for their hard work.

Politics & other leaders

The year 2013 brought its share of political changes. In January, long-serving Health Minister John Hill passed the health 'baton' to Treasurer Jack Snelling, who took the portfolios of Health, Mental Health and Substance Abuse. In February, new Opposition leader Steven Marshall, formerly the Shadow Minister for Health, announced that long serving Liberal MLC Rob Lucas, a former state Treasurer, would take the role of Opposition Health Spokesman. Thus we are talking to two former Treasurers about SA's health needs into the future, and both have a keen interest in the fiscal bottom line. Nevertheless, conversations proved constructive on several key fronts. We met with both throughout the year, also meeting with Premier Jay Weatherill and Dignity for Disability MLC Kelly Vincent and Disabilities Minister Tony Piccolo, among others. With 2013 including a federal election, and the lead-up to a state election in March 2014, it was a particularly important year politically and for advocacy.

Our regular meetings with the Minister included the Chief Executive of the Department of Health, Chief Medical Officer, and Chief Public Health Officer, as well as other Departmental leaders. We also met and liaised with other leaders in health, and similar organisations, including the Cancer Council, Heart Foundation and Asthma SA, and the Law Society of SA, to name just a few. These meetings and collaborations provided important

opportunities to work together on areas of shared interest and concern.

We have also continued to bring other medical entities under the AMA(SA) 'roof', which will provide more opportunities for collaboration and shared endeavours. In 2012 we signed a memorandum of understanding with the Chinese Medical Association SA and we continued to strengthen our links with this vibrant group in 2013. In addition to providing secretariat support to the Australian Society of Anaesthetists (SA) and the SA Indian Medical Association, in 2013 we signed an agreement to also provide that support to the Pakistani Medical Association, which now joins these other key groups at Newland House. Our long and proud support of the Medical Benevolent Association of SA also continues, and we are supporting the Adelaide AMSA team which is working towards the staging of the national Australian Medical Students' Association Convention in Adelaide in 2014.

Public affairs

Speaking engagements provide an important forum to help spread the word and contribute to the debates and conversations that are so important to have in health. Some of the highlights for me in 2013 were speaking to our leaders of tomorrow at the Flinders Medical Students' Society's Leadership Development Seminar; on e-health at a Consumers Alliance Forum; at the Southgate Institute for Health, Society and Equity's policy club session on the future of primary health; and as a panellist with the Health Minister and others at an Adelaide Medical Students' Society health forum.

Media comment continues to be an important part of the job, with the AMA(SA) ready to provide a balanced view and a medical opinion not only on health policy but a range of issues in health and medicine. Public health topics are a key focus, and we dealt with over 200 media enquiries throughout 2013. The queries were as wide in range as medicine itself and have covered topics from hayfever to binge drinking, and from health funding to GP Super Clinics.

With so many competing voices and 'experts' in health it remains important to present informed comment on health issues, and it was a privilege throughout 2013 to participate on a fortnightly 'health spot' on ABC 891 radio with Afternoons presenter Sonya Feldhoff. The focus of the segment, 'I've got what', was to discuss various common (and some uncommon) ailments, with some general and practical health advice thrown in, including an interactive aspect. We received much positive feedback on this initiative, in which we have the opportunity to give the advice of the consulting room in the car, the loungeroom, the workplace, or wherever the listener sits.

We have also co-branded and supported in 2013 a number of Government public health campaigns, helping to spread and reinforce messages that will support better health for our patients and the communities we serve.

Communications

We have throughout 2013 enhanced our communications in a number of ways. Our Editorial Committee has become a Communications Committee, and a new Communications Strategy was put together by Director of Communications Eva O'Driscoll, presenting a model to help us better co-ordinate and spread our messages. We have redesigned our email communications and relaunched our members' newsletter as *The Voice*, which provides even more content and up-to-date information than before. Meanwhile, under our Communications team, led by Phil Harding as Editor, our state magazine continues to excel again winning the title of Best State Publication from among the states in 2013.

We launched a new, improved website, based on the federal AMA's web platform, providing valuable benefits as well as the capacity to join and renew membership online. Now members who visit our site can access there both SA content and the full range of federal AMA content, including position statements, practice support and national member benefits.The SA site also includes AMA(SA) submissions, news and media comment as well as other important information.

We have expanded the SA resources available online, including advice from government departments, and some legal requirements, updates and regulations, and Coroner's findings, and will look to further improve and build on this new foundation, further integrating our resources and information across communication platforms.

Policy & advocacy

The branch made an impressive number of submissions throughout 2013 (over 30), to Government, the Opposition and other politicians, and the Department of Health, among others. Topics ranged from reporting requirements for dog biting, to euthanasia, and were prompted by draft bills, legislative requirements, SA Health directives and various reviews and reports. We provide a response to almost every submission request we receive (and some we don't), often highly detailed documents, informed by the expertise of our dedicated Council and committee members, as well as members specialising in the relevant fields.

This is not to no avail. Our submissions, recognised as informative and authoritative, are referenced by other groups, and in government reports. Their words can often be found echoed in government announcements, and you can find us in Hansard as well.

Several successfully passed amendments to Bills in 2013 directly related to AMA(SA) advocacy, perhaps most notably the Advance Care Directives Bill. We have also lent important state support to a number of federal AMA campaigns and advocacy, such as that against the proposed $2000 tax cap on self-education expenses, and those for the ratification of the Optional Protocol to the Convention against Torture, and implementation of the Electronic Recording and Reporting of Controlled Drugs system. You can read more about advocacy areas in 2013 on pages 7 to 10.

Members

Last but not least, much of our work is informed by the direct input of members, who bring issues to our attention, meet with us and represent the profession on state and federal AMA Councils and committees. I have spoken to many members throughout 2013. It has been a pleasure and a privilege to be able to help members with the varied issues you may face personally and professionally, in your practices, hospitals and the many areas in which we work; and also to be assisted by members in the work of the AMA. We are your Association – we are your colleagues and you are ours. Together there is much we can do – and much we do achieve. Thank you for your support in 2013 in all its forms.

Joe Hooper
AMA(SA) CEO

From the Chief Executive Officer

This year we have progressed with the strategy we initiated in 2011. We have continued to focus on our partnerships with other medical associations and seek commercial opportunities where we see a benefit for our members and potential for growth of the Association. In particular we have established stronger ties with culturally based medical associations and now host several within our secretariat. This is consistent with our expressed intention to provide a 'medical home' for members of the profession, regardless of whether they consider membership of the AMA as something they wish to take up at this time. This reflects our attitude that the AMA, as the peak medical body in Australia, should have an open door to all doctors at all times and be welcoming and willing to assist when able. This does not mean non-members receive any of the direct member benefits, of course, as this would be unfair to our members, but it reflects our mission to provide an umbrella association for all doctors and hopefully increase our membership over time.

Governance changes update

Following the 2012 Special General Meeting, the AMA(SA) formed the inaugural Executive Board in January 2013, electing Dr Trevor Mudge as the first Chair. Since then the Board has undertaken its fiduciary role most efficiently and the AMA(SA) has benefited by having a dedicated focus on important governance and financial matters. From a CEO perspective, I feel the Association has strengthened in its financial planning and management process as the Board grapples with the important fiscal constraints and future needs of the Association. For example, the Chair has attended meetings with me to specifically examine our investment in future business development, future building management assessments, financial partnership arrangements and similar activities related to corporate governance. All matters are reported to the full Council on a quarterly basis.

Accounting & financial management

The AMA(SA) budget and audit results, under the supervision of the Executive Board and CEO, are all compliant with the Incorporated Associations legislation. We continue to show a small but positive balance in our annual financial results of $59 563. Whilst this is less than our previous year, our overall end-of-year current asset position ($827k) and total equity ($4,107K) are both improved compared to the 2012 result ($643K and $4,047k respectively) demonstrating we continue to show an improved financial position overall. The AMA(SA) discontinued receiving any financial support from AMA federal office in 2011 and this looks likely to continue into the future.

Expenditure has been controlled through the ongoing review of our operational costs and we have adjusted provider contracts and reduced outgoing costs for telecommunications and other office infracture where possible. The Executive Board undertakes a regular budget review six months into the financial year to ensure we are within forecasts and adjustments are made and provided to Council as necessary. This close monitoring of our expenses against budget and ensuring we estimate future expenses conservatively has ensured we consistently return under or neutral budgets.

Whilst we have respected our limited discretionary financial reserves, the Board made the important decision that we must continue to invest in service growth initiatives with a strategic purpose of decreasing our dependence on membership subscriptions, which remain our main source of income for the running of the South Australian office. The development of commercial income is a key area for future growth and reducing pressure on membership fees. For this reason we have invested in developing a Registered Training Organisation as a future key division of the AMA(SA) (see page 6).

Property

The Association's property management over AMA House remains solid, with uninterrupted rental returns in a continuing soft rental market. Again this year there were no untenanted properties and all lease options have been exercised. A vacancy was created in unit 8A in AMA(SA) House in December 2013 but this is intended to be occupied in January next year.

Newland House requires significant ongoing maintenance and, as previously reported, provides limited future use as offices without structural upgrade. This issue is a priority being examined by the Executive Board.

Staffing

Our employee FTE numbers remain small (6) and all staff assist across the Association's activities. The resignation of Ms Lucie Briscoe, Business Development Manager, in September 2013 was unexpected but we appreciate staff will seek career progression and a small organisation like the AMA(SA) will always find it difficult to compete in this area. The AMA(SA) is undergoing further changes internally and the Business Development role will be filled once the restructure is completed.

Ms Eva O'Driscoll, Director of Communications, has worked diligently to provide our many policy submissions,

media comment and website content, as well as broader communications. Eva provides the necessary support for our President by way of background briefings and coordinating media appointments. The role can be very busy at times and ensuring the best results for our members' concerns is often a balancing act as we juggle our limited resources. Eva has undertaken this role with great effect and energy.

Ms Tracey DiBartolo's role as Affiliated Associations and Committee Officer has continued to expand as we welcomed the Pakistani Medical Association into our building to join the Australian Society of Anaesthetists and the Indian Medical Association. Welcoming local medical associations into our building and the AMA(SA) family is consistent with our overarching principle of being open to all members of the medical profession. Other organisations are expected to join in 2014.

We welcomed a new employee in Mrs Melanie Caruso in April 2013 as our Membership Support Officer, a role which has been expanded to include events. Melanie previously worked in membership recruitment and brings enthusiasm and passion to the role. She will be delivering more Association events and our members will quickly get to know Melanie, who is the first point of contact for all member inquiries.

Our other staff members include Mr Stewart Gillies, Accountant, Ms Isabelle Watts on reception (Isabelle is working with us whilst she undertakes her Masters degree in primary education), and Ms Claudia Baccanello, who is well known to most members and continues to provide indispensable support for the President, CEO and Executive. Heather Millar is also a key part of our extended team, providing great support as the Managing Editor of medicSA, working with Eva and Communications Committee Chair Dr Phil Harding.

Public relations

Our public relations portfolio remains impressive, with regular meetings with key leaders in health both at the state and national level. Politicians (state and federal), SA Health, specialist colleges, and professional associations, SASMOA, Deans of Medical Schools, the Medical Board of Australia, AHPRA, WorkCover, the Law Society, Pharmacy Association and Pharmacy Guild, ANMF, and Dental Association are all part of our network, ensuring the AMA(SA) can consult broadly and exert influence across all areas of the health sector.

Membership

The transfer of membership renewal functions to AMA (NSW) has continued to result in more efficient renewal and retention rates, with AMA(SA) being the national leader in retention renewal rates in December 2013. The AMA(SA) office continues to handle dispatching of membership kits for new members and to handle local inquiries to ensure we are connected to our members.

We have continued our efforts to support doctors in training and medical students. In 2013 we have provided office support for the organising committee for next year's AMSA national medical student convention, when over 1000 medical students will descend on Adelaide for three days. Medical students are represented on our State Council and our Doctors in Training Committee remains active and engaged. This is having a positive impact on attracting younger members.

Whilst our membership results are the best we have seen in the past four years, attracting new members remains challenging. We continue to see doctors seeking membership after they find themselves in a professional predicament. We advise of our policy that the AMA(SA) will not assist in pre-existing issues unless there is illness or a matter affecting the whole profession. We promote AMA(SA) membership as 'insurance', something you have in case you need it, whilst at the same time members can make the most of our exclusive member benefits along the way.

Registered Training Organisation

The AMA(SA) appointed Mrs Kathy Stanton AM, Consultant, and Mrs Michelle Cockshell, Student Coordinator, in March 2013 to assist with developing our Registered Training Organisation (RTO). This is a significant undertaking for the AMA(SA). The Association undertook a membership-wide survey seeking comment on this initiative and we received overwhelming support.

Since March 2013 the assembled team have developed training programmes and assessment procedures in preparation for Australian Skills Quality Authority (ASQA) accreditation. Once this work is completed AMA(SA) will be providing Certificate 3 and 4 and Diploma level training across a range of health-related qualifications including practice management, aged care, disability care, fitness and leisure, and health administration.

The AMA(SA) strongly supports this initiative. We recognise the importance of quality education and training in the health sector. We intend to become a significant contributor to quality training of staff who can work in medical practices and other health settings. Accreditation and the launch of this new enterprise is anticipated in around May 2014.

Youth Friendly Doctor Program

The AMA(SA) remains committed to further developing our Youth Friendly Doctor Program. Unfortunately, the State Government refused further funding beyond last year and we have been unable to secure alternate funding for this important program, so we have only been able to deliver two modules in 2013. We consistently have difficulty attracting sponsorship for this program but are determined to keep up our efforts and nurture our partnerships with the school education and youth sector.

Appreciations

Finally I would like to acknowledge the work of Dr Patricia Montanaro, who has worked tirelessly during her term as President. Patricia has engaged with the membership, key health stakeholders and media across a range of issues. Her regular afternoon radio segments are popular and do much to ensure positive public recognition of the AMA(SA) and the profession. I also thank all Councillors for their availability and the high standard of advice and support they provide. They contribute their time voluntarily for the benefit of all doctors in this state. Finally, I sincerely thank all the staff for their invaluable support and dedication to the AMA(SA). They are the engine room of the AMA(SA) and without their hard work the AMA(SA) would not achieve the high level of productivity we provide every year that leads to the recognition and respect we are afforded throughout South Australia.

AMA(SA) Advocacy | 2013

State Budget
SA Premier and Treasurer Jay Weatherill handed down his first budget on 6 June, with a mixture of good and bad news for health. The 2013-14 budget included funding to continue works at the new Royal Adelaide Hospital, and $41.3 million to support the South Australian Health and Medical Research Institute and attract specialty medical research groups.

The Government highlighted country health and mental health as key areas, and flagged money for developments at other hospitals.

The health budget also included savings of $47.3 million across the forward estimates, and reductions in staff. The AMA(SA) expressed its concern at the effect that budget cuts can have on the front line, with health being asked to do more with less.

While some of the budget announcements were welcome, health services that are struggling to deliver the care needed while meeting budget measures will have some invidious choices to make.

New Royal Adelaide Hospital
The AMA(SA), together with the Australian Nursing and Midwifery Federation (SA) and Salaried Medical Officers Association gave evidence in July 2013 to the Budget and Finance Committee of SA Parliament's Legislative Council to discuss the progress of the new Royal Adelaide Hospital (RAH) development, providing the opportunity to highlight some of the questions and concerns being raised.

The new Royal Adelaide Hospital is set to open in the Health and Biomedical Precinct in mid-2016, but there is still uncertainty on what services will be provided, concerns on capacity and questions on new models of care. The AMA(SA) has been calling for more information to be released to provide the opportunity for broad and meaningful input into what and how services are to be provided in this crucial element of SA's "spine" of adult tertiary hospitals.

University of Adelaide move
The AMA(SA) welcomed the June 2013 announcement that a new facility for the University of Adelaide's medical school will be established at the new city health precinct. The $120 million new facility will incorporate medical and nursing schools, with dentistry also discussed for inclusion (currently at an impasse). A new centre for cancer research has also been announced for the precinct.

The AMA(SA) is calling for a master plan to be developed for the new precinct which maps out and includes all the elements needed to ensure that this significant investment in health in this state can meet its impressive potential.

WCH co-location
The AMA(SA) welcomed Premier Jay Weatherill's announcement in October 2013 of the future co-location of the Women's and Children's Hospital (WCH) with the new Royal Adelaide Hospital, as a key component of the biomedical hub. We have long advocated for this move and believe it to be an important step in bringing South Australia in line with what is now considered the benchmark for providing women's and children's health services.

The health benefits co-location can offer are significant. They include improved access to specialist medical services and thus improved patient care, together with more cost-efficient use of clinical and other resources. The AMA(SA) also welcomed SA Health Minister Jack Snelling's confirmation that the new, relocated Women's and Children's Hospital would keep its name, identity and culture. Needless to say, consultation will be crucial to get this right.

Budgets & paediatrics
The Women's and Children's Hospital was the subject of a review undertaken by Deloitte and released in June 2013, which was criticised by the AMA(SA). The review focussed on budget performance and efficiency but used inappropriate 'peer' hospital comparisons. Budget-driven, it did not consider clinical outcomes or quality. The Association urged that the focus should be on patient safety and quality, not staff and budget cuts, with recognition of the circumstances of the hospital and the realities of care.

The Association also cautioned against timing reductions at the WCH at the same time as the proposed closure of the Modbury inpatient paediatrics ward. While the AMA(SA) would prefer the facility at Modbury be maintained, it emphasised that if services are moved to the Lyell McEwin Hospital, the existing paediatric outpatient clinic must continue and be enhanced, also stressing the need for appropriate staffing of the Emergency Department.

Commissioner for Children
The AMA(SA) welcomed in 2013 the government's proposal to introduce a Commissioner for Children and Young People in SA, an office long advocated for by the AMA(SA) to oversee the integrated provision of services to children. The Association re-iterated its call for the establishment of a Commissioner in its submission to an October 2012 consultation process, also calling on the state government to establish an Office for Children and Young People.

In 2013, we provided a comprehensive response to the government's draft Child Development and Wellbeing Bill, which introduces the role. The AMA(SA) considered the draft bill to be a significant improvement on the initial discussion paper but raised the need for appropriate funding and independence. A statewide plan for

children's services, including the community connections, must follow.

Mental health
Mental health has continued to be a key area of advocacy of the AMA in 2013, following on from the Association's previous (and ongoing) advocacy on the need for more acute mental health beds and acute forensic mental health beds, and related pressures on emergency departments. A review into the number of mental health beds was announced and undertaken in 2013 but the AMA(SA) questioned some of its findings.

The review delivered a range of broad recommendations, including the conclusion that the actual number and mix of psychiatric beds is appropriate – a view with which the Association strongly disagreed and will continue to challenge. We called both for a review of the intermediate care model and a population needs analysis.

Child & adolescent mental health
The AMA(SA) has been a strong advocate for the state's well renowned eating disorders treatment program, and services are now expanding, with the announcement of a new eating disorders hub to be located at Flinders Medical Centre. The Association has emphasized that it will be important to get the planning and coordination right to make the most of this initiative.

On a related note, during 2013, the AMA(SA) advocated for the return of the Ward 4E child and adolescent mental health team back to the Southern Adelaide Local Health Network. This realignment would reconstitute the combined Ward 4E paediatric and psychiatric eating disorders team, a move that is strongly supported by eating disorders specialists. The AMA(SA) holds that the ward should be included in a fully integrated approach to the treatment of adolescent eating disorders that includes the provision of dedicated paediatric beds.

Mental health management
The AMA(SA)'s call for centralised mental health bed management to be devolved back into Local Health Network control has finally been answered. We had been concerned that bed management problems were being exacerbated by the retention of a convoluted centralised bed management bureaucracy.

The Association also called for clinical leadership reform under the devolved governance model, with clinical leaders to manage public sector psychiatric services where bureaucratic oversight has failed. This would bring mental health in line with the governance across all other areas of health, such as surgery and medicine, where we have clinical heads with management and clinical responsibility and authority.

Road safety & young people
The AMA(SA) has long highlighted the dangers faced by young people on our roads. In 2013 the Association supported changes to the Graduated Licensing Scheme for young and learner drivers in South Australia. The changes included a passenger restriction rule for P1 drivers, allowing no more than one passenger aged 16 to 20 years (immediate family members are exempt), and a night-time driving restriction for P1 drivers between midnight and 5am (with an exemption system).

The Association is also working with SA Police to highlight the dangers of alcohol and drug use to young drivers, with more work in this important area set for 2014. Preventing the harms of alcohol to young Australians has been a national priority area for the AMA, with the Association drawing attention, in particular, to the marketing of alcohol to young people.

Motorcycle licensing
The AMA(SA) and SA Regional Trauma Committee of the Royal Australasian College of Surgeons provided in 2013 a joint response to the Minister for Transport on proposed changes to motorcycle licensing. Both organisations were supportive of the changes proposed, which seek to reduce the high rate of death and injury associated with motorcycle use, for example, through requiring additional training time and that a car licence be held for a longer period of time before a motorcycle licence is granted.

Fitness to drive
On the other end of the driving spectrum, the AMA(SA) criticised the government's new Fitness to Drive forms, released in 2013, as well as their implementation. Strong advocacy from the AMA(SA) during 2013 regarding the new forms reaped rewards with a new and improved form to be issued in 2014 and a promise from the Department (DPTI) of ongoing engagement to further improve the forms to make them more user friendly, and better achieve their objectives of providing useful information on conditions that may affect driving capacity and safety.

Also under discussion in 2013 was the proposed removal of the 70-year age limit threshold requiring medical assessment, and what measures could come instead: AMA(SA) work in this area will continue in 2014.

Problem gambling
The adverse impacts of problem gambling have been of concern to the AMA for some time and at the start of 2013 the federal AMA released its updated position statement on this important topic. In SA, we welcomed the banning in 2013 of live odds betting advertising during sport, which was followed by state government initiatives regarding children, technology and gambling.

The AMA(SA) also partnered in 2013 with the Office for Problem Gambling to help raise awareness among GPs of what they can do to identify and help patients who may be affected by a gambling problem. The campaign, which continues into 2014, includes a website-based resource to assist with identifying, assessing, screening, treating and referring people affected by gambling problems, as well as resource materials distributed to general practitioners.

McCann Review & public health
The October 2012 McCann Review into Non-Hospital Based Services was a topic of continued concern in 2013, with the AMA(SA) making a submission in response in February 2013. The review recommended budget and job cuts in the primary health care area, looking towards Commonwealth government uptake, but the AMA(SA) expressed concern that the targeted services cover vulnerable groups, and Commonwealth uptake is not guaranteed.

The Association also warned that the review was not sufficiently informed, with its final key message being that health prevention and health promotion need more support: not less.

Smoking, drugs and alcohol
The AMA(SA) criticised significant cuts to drug and alcohol services in SA, as well as to Cancer Council and Quit services – with key concerns including cuts to step-down services and hospital avoidance measures.

The AMA(SA), Cancer Council SA, Heart Foundation and Asthma Foundation banded together against the government's decision to remove $1.3 million per annum from the anti-smoking advertising budget. The Association holds that the financial consequences in terms of lost productivity and health spend as a result of more people smoking quickly erodes any immediate cost savings.

On a more positive note, tobacco product displays have been eliminated at the point of sale, and the government made moves forward in 2013 on proposed bans on smoking in outdoor drinking and dining areas – both areas of AMA(SA) advocacy.

Misuse of controlled drugs has also been the subject of AMA attention. The Association is advocating at state and national levels for the implementation of the ERRCD (Electronic Recording and Reporting of Controlled Drugs) system as an important and practical measure to counter misuse of controlled drugs and save lives.

Advance care directives
The Advance Care Directives Act was passed in 2013. The AMA(SA) has long supported advance care planning and highlighted the lack of clarity around previous advance directive legislation. The Association made a submission to the review which informed the new legislation and won important amendments regarding conscientious objection and provisions for emergency situations. The next step will be practical tools, resources and roll-out to help the new legislation meet its promise.

Importantly, the new Act rectifies issues with section 17(2) of the Consent to Medical Treatment and Palliative Care Act which has been interpreted to mean that medical practitioners can be compelled to provide treatment to terminally ill patients that is without benefit to the patient.

Voluntary euthanasia bill
During 2013 the AMA(SA) strongly criticised as flawed two Bills regarding end of life, one on euthanasia and one proposing amendments to the Consent Act regarding artificial nutrition and hydration. Concerningly, the Ending Life With Dignity euthanasia bill proposed as mechanisms of euthanasia actions that currently can occur as part of accepted palliative care, and the AMA(SA) expressed its strong concerns that both bills were flawed, and would be detrimental to good palliative care if they became law.

Homebirth
The AMA(SA) in 2012 gave evidence for a Coroner's case that examined three deaths associated with home births. The Coroner recommended that legislation be introduced that would render it an offence for a person to engage in the practice of midwifery without being a registered midwife or medical practitioner.

The AMA(SA) believes that, if undertaken, homebirthing must be within the parameters of the lowest potential risk to the baby and mother, and must also be within the context of fully informed consent. The state government responded in 2013 to the Coroner's recommendation with a discussion paper 'Proposal to Protect Midwifery Practice in South Australia' and subsequent legislative change, supported by the AMA(SA) and backed up by an AMA(SA) submission in response to the issues raised.

Patient Assistance Transport Scheme
The inadequacy of the Patient Assistance Transport Scheme (PATS), which is intended to assist with travel and accommodation costs for rural patients requiring city-based treatment, as long been a topic of AMA(SA) advocacy. The Association welcomed a review of the scheme announced by the government in 2013, making a comprehensive submission in response, in which we again made the case for increased funding.

Rural practice
The AMA(SA) toured the Eyre Peninsula in 2013, with then President Dr Peter Sharley and CEO Joe Hooper visiting local general practitioners and health services to find out more about challenges on the ground and what is needed to help support health care in our rural communities. Workforce challenges and the need to attract young doctors to rural practice remain at the top of the list, as well as the need to reduce red tape and improve teleconferencing facilities.

The AMA(SA) also successfully negotiated with Country Health in 2013 on behalf of doctors at Victor Harbor, Middleton and Goolwa, on agreements to provide services to the South Coast District Hospital. The 'one size fits all' agreement put forward by Country Health did not suit the requirements in the region, and the AMA(SA) was glad to be able ensure an improved agreement was reached.

GP after-hours contracts
In response to members' concerns about the Medicare Local after hours contracts for GPs, the AMA(SA) convened a forum in July, in collaboration with GP Partners Adelaide. It attracted a core group of members and practice managers

representing hundreds of general practitioners and 18 practices across South Australia, many of which are multi-site practices. Presentations were given by the AMA(SA) and GP Partners Adelaide, with legal aspects also discussed by Norman Waterhouse Lawyers. The forum resulted in a formal request from attendees that the AMA(SA) pursue the issues raised and provide local support and advice, which proved beneficial for members.

Increased penalties for assault
The AMA(SA) in 2013 welcomed two initiatives aimed at deterring violence against health professionals: a bill from the Opposition, and proposed regulation changes introduced by the Attorney-General. The regulations put by government would cover hospitals – with possible extension to GP Plus and GP Super Clinics. The AMA(SA) called for any increased penalty provisions to cover health professionals acting in the course of their work generally, in whatever setting.

Reporting deaths
The AMA(SA) gained amendments to the Burial and Cremation Act to counter significantly increased penalties for medical practitioners for issuing a certificate of cause of death if the death is one that is required to be notified to the coroner, or in certain other circumstances. The AMA(SA), which gained support from the Law Society (SA) in this matter, successfully held that the proposed penalties were too high, particularly considering that in the vast majority of cases any errors made would be honest mistakes made in good faith. We also raised considerations regarding rural areas, which also prompted positive amendments to the bill before it passed.

Detention, restraint & consent
The AMA(SA) in 2013 provided feedback on a proposed SA Health directive on providing medical assessment and/or treatment where patient consent cannot be obtained, and also on proposed measures to deal with a legislative gap regarding the detention and restraint of patients who lack, or appear to lack, capacity. Patients who are violent, confused, affected by drugs or alcohol, or in the midst of a mental health crisis, are highly challenging to treat and actions that are taken in the patient's best interests may leave medical practitioners legally exposed. The AMA(SA) sought in its advocacy and responses in 2013 to gain clarity, support and legal protection for health practitioners whose work places them in these difficult situations.

Scrap the Cap
The AMA(SA) worked with the federal AMA and other state branches and members of the Scrap the Cap Alliance in 2013, to lobby strongly and successfully against the proposed $2000 cap on tax deductions for work-related self-education expenses. The AMA's advocacy on this issue combined national strength with local activity, highlighting the issues regarding the proposed cap. This included a key meeting in Adelaide with federal Liberal MP Christopher Pyne at which federal AMA President Dr Steve Hambleton, AMA(SA) President Dr Patricia Montanaro and state CEO Mr Joe Hooper joined other members of the Scrap the Cap Alliance to argue the case against the cap.

Individual AMA members made a big difference in this campaign by highlighting the impact the proposed cap would have on medical education, particularly for rural doctors and doctors in training, providing examples and grassroots support for the campaign, which achieved its objective of a 'scrapped' cap.

Intern positions & medical training
AMA(SA) advocacy over past years has helped to ensure guaranteed intern positions for SA medical graduates. The Association was very glad that the 2012 and 2013 graduating South Australian students who wanted them all gained places. This included international students who sought a position in SA, as well as a number of interstate graduates. The Association remains concerned for those graduating in 2014 and for future years of training. The AMA has been lobbying strongly for a national intern allocation system and for all governments to work together to ensure that Australian-trained medical graduates can access intern and later training positions.

The AMA(SA) also expressed its concern in 2013 about rotation arrangements for junior doctors within Local Health Networks (LHNs). The concern is that while the central intern allocation process administered by SA MET has transitioned to assign individual interns to LHNs rather than specific hospitals, some networks continued to place interns largely or exclusively at single hospitals, obviating the equitable rotation of interns: we hope to see improvements in 2014.

Special Purpose Funds
A key concern for research and public hospital doctors in 2013 was SA Health's increased financial controls over hospital Special Purpose Funds, with recurrent blockages resulting for research and education. Any relevant governance issues need to be addressed, but it is vital that this valued resource is not compromised.

Special Purpose Funds play a significant role in providing many important medical activities in our public hospitals, including vital research, PhD scholarships, research assistants, nurses and specialized medical equipment.

The AMA(SA) warned the Minister that interfering with these funds would have a huge impact on research and medical activity across the public health system. The Association worked throughout 2013 to see Special Purpose Funds released for the purposes for which they were established, with a particular focus on those relating to research and education. Our advocacy saw progress in 2013 on this important issue, which will remain a high priority in 2014.

Highlights | 2013

Student medal winners

The AMA(SA) awards two Student Medals each year: one to a graduating medical student at the University of Adelaide and one to a graduating medical student at Flinders University. The medals acknowledge both academic excellence and contributions to the School of Medicine through representing the interests of students, and involvement in student life, the university or general community. In 2013 we were delighted to present Student Medals to Thomas Crowhurst (Adelaide) and John Floridis (Flinders). Both have made significant contributions among students and in their schools, in addition to their academic achievements, and John was also this year a member of our AMA(SA) State Council.

AMA(SA) Awards

One of the highlights of each year is the opportunity to confer a number of prestigious awards at the AMA(SA) annual Charity Gala Dinner. In 2013, the inaugural Medical Educator award was conferred on the late Dr Conrad Williams, the President's Medical Leader Award (previously known as the President's Award) was awarded to Dr James Muecke, Chairman of the Sight For All Foundation, and the AMA(SA) Award for Outstanding Service was awarded to Yorketown GP Dr George Kokar. The AMA(SA) Outstanding Achievement Award, which has been given only twice before, was awarded to former AMA(SA) President and federal AMA Treasurer Dr Peter Ford. Dr Ford was also awarded the federal AMA President's Award at the AMA 2013 National Conference.

Life Members

Each year the AMA(SA) is proud and privileged to accord life membership of the Association to members who have supported the AMA(SA) through 50 years of membership. Without the support of such dedicated members we would not be where we are today. Five long-term AMA(SA) members were made Life Members of the Association at the start of 2013. Our sincere thanks go to Dr Carolyn Harriet Dearlove, Dr John Henry Gardner, Dr Adrian Alhard Von Der Borch, Dr Susan Rae Clisby and Dr Robert Barham Black for their support of the Association, as well as their service to patients and support of colleagues.

New AMA(SA) preferred providers

The AMA (SA) was glad to welcome two new preferred providers in 2013, a new preferred provider of payroll services, GP Payroll, and a travel services provider, Thesinger and Turner Travel Associates. These join other AMA(SA) preferred providers Hood Sweeney, Commonwealth Bank and Norman Waterhouse Lawyers, with benefits also offered through the BMW Corporate Program.

Training and Education

The AMA(SA) holds and supports a number of events to help members and their staff develop skills and knowledge. In 2013 these included a full-day seminar for AMA(SA) members on Preparing for Private Practice, and a breakfast session on Practice Succession. We also held a very successful Youth Friendly Doctor Program Workshop on adolescent health issues, which included general practitioners, junior medical officers, allied health providers and medical students.

AMA(SA) and WorkCover Joint Statement

The AMA(SA) and WorkCover in 2013 produced a joint statement of common goals reflecting the role of medical practitioners in the SA workers' compensation system. The Joint Statement of Common Goals reflects both organisations' commitment to achieving a common understanding of the role of medical practitioners operating within the South Australian Workers Compensation Scheme. The AMA(SA)'s work and advocacy in this important area will continue.

Events and Charity Support

The AMA(SA)'s annual black tie charity Gala Dinner at the Hilton International Adelaide on 11 May was again a great success, providing a chance to catch up with colleagues. The 2013 dinner supported the SA Spinal Cord Injury Research Centre and A Drop in the Buckett, which raises funds for spinal research. Thanks to the support of those who attended we were glad to be able to donate $10,000 to the SA Spinal Cord Injury Research Centre. The silent auction raised over $6000 for A Drop in the Buckett.

Another highlight of the year was the Melbourne Cup Lunch held jointly by the AMA(SA), the Law Society of South Australia and the Institute of Chartered Accountants Australia, held at Adelaide Oval. Charities that benefitted from the lunch were the Cancer Council, Smith Family and Mary Potter Foundation, with each receiving $5000.

Retired and life members of the AMA(SA) also joined past presidents of the Association for the ever popular AMA(SA) special annual luncheon at the Adelaide Oval in November. Last but not least, the annual Christmas party held jointly in November with the RACGP SA&NT again proved a great family-friendly event, enjoyed by members of both organizations, and the annual President's Breakfast provided an important opportunity to say thank you to all those who help and work with the AMA(SA) thoughout the year.

Medico-legal register

The AMA(SA) has been working with the Law Society of SA to improve access to medical specialists for WorkCover, Allianz and public liability claims patients. Towards this objective, the AMA(SA) in 2013 launched an online register of practitioners who are prepared to undertake medico-legal consultations and prepare reports.

AMA(SA) Council | Changes

Changes to the AMA(SA) Council during the year 2013

Retiring Councillors

- Dr Penelope Briscoe retired from the position of Ordinary Member, a position she has held since June 2012.
- Dr Andrew Wicks retired from the position of Craft Group Representative for Radiologists, a position he has held since June 2011.
- Dr Janice Fletcher retired from the position of Craft Group Representative for Pathologists, a position she has held (as a Casual Vacancy) since June 2012.
- Dr Andrew Russell retired from the position of Craft Group Representative for Physicians, a position he has held since June 2011.
- Dr William Tam retired from the position of Ordinary Member, a position he has held since September 2012.
- Dr Andrew Lavender retired from the role of Area Representative for SA/NT on Federal AMA Council, a position he has held since May 2008, and the concomitant ex officio role on AMA(SA) Council.
- Dr Peter Ford retired from the role of Treasurer on Federal AMA Council, a position he has held since May 2009, and the concomitant ex officio role on AMA(SA) Council.
- Council acknowledged with great appreciation the contribution of the late Dr Conrad Williams, who represented Salaried Medical Officers (2009 – 2012) and Emergency Physicians (2012 – March 2013).

Election of Office Bearers

- Dr Patricia Montanaro was elected to the office of President.
- Dr Janice Fletcher was elected to the office of Vice President.

Election of Craft Group and Other Representatives

- **Craft Group Representative – Anaesthetists** – Dr Margaret Cowling was re-elected to this position by AMA(SA) Council.
- **Craft Group Representative – Emergency Physicians** – Dr Hendrika Meyer was elected to this position by AMA(SA) Council.
- **Craft Group Representative – General Practitioners** – Dr Christopher Clohesy was re-elected to this position by AMA(SA) Council.
- **Craft Group Representative – Obstetricians and Gynaecologists** – Dr Stephen Lane was re-elected to this position by AMA(SA) Council.
- **Craft Group Representative – Pediatricians** – Dr Andrew Kelly was elected to this position by AMA(SA) Council.
- **Craft Group Representative – Pathologists** – Dr Heather Cain was elected to this position by AMA(SA) Council.
- **Craft Group Representative – Physicians** – Dr William Tam was elected to this position by AMA(SA) Council.
- **Craft Group Representative – Psychiatrists** – Dr Michelle Atchison was re-elected to this position by AMA(SA) Council.
- **Craft Group Representative – Radiologists** – There being no nomination received by the AGM, Dr Nicholas Rice was appointed to this position by AMA(SA) Council.
- **Craft Group Representative – Surgeons** – Dr David Walsh was re-elected to this position by AMA(SA) Council.
- **Salaried Medical Officers' Representative** – Dr Andrew Russell was elected to this position by AMA(SA) Council.
- **Doctors in Training Representative** – Dr Andrew Shepherd was re-elected to this position by AMA(SA) Council.

Appointments of Ordinary Members

- Dr Peter Ford was appointed by AMA(SA) Council to the Casual Vacancy of Ordinary Member.
- Dr Emma Rischbieth was appointed by AMA(SA) Council to the Casual Vacancy of Ordinary Member.

AMA(SA) Standing Committees

January - December 2013

Doctors in Training Committee

Chair: Dr Andrew Shepherd
Immediate Past Chair: Dr Rick Fielke
Secretariat: Mr Joe Hooper, Ms Tracey DiBartolo
Members: Drs Manuel Aranibar, Lachlan Farmer, Patricia Montanaro, Tom Paxton and Emma Rischbieth
Student Medical School Representatives: Mr Shane Selvanderan and Mr Sanjivan Mudaliar
Reference Group Members: Drs Adam Badenoch, George Balalis, Phil Deacon, Tony Farfus, John Floridis, Edward Gibson, Mark Hassall, Adam Nelson, Minh Nguyen, Andrew Perry, Kristen Pierides, Daina Rudaks, Ross Roberts-Thomson, Rahul Solanki, Brenton Systermans, Sam Whitehouse and Ms Victoria Cox

Council of General Practice

Chair: Dr Chris Clohesy
Secretariat: Mr Joe Hooper, Ms Tracey DiBartolo
Members: Drs Sue Baillie, Mike Beckoff, Tony Cocchiaro, Phil Deacon, Peter Ford, Richard Heah, Andrew Kellie, Tim Kelly, Jane Kitchen, Oluwadare Kuku, Muhammad Masud-Ul-Haq, Sarah Meertens, Patricia Montanaro, Christopher Moy, Roger Sexton, Peter Tait, Max Van Dissel, Chris Wagner, Kamal Wellalagodage, Georgina Whiting, John Williams, and Mr Karthik Venkataraman

Communications Committee

Chair: Dr Philip Harding
Secretariat: Mr Joe Hooper, Ms Eva O'Driscoll, Ms Heather Millar
Members: Drs Tony Farfus, Mark Hassell, Bill Heddle, Jeanette Linn, Robert Menz, Patricia Montanaro, Christopher Moy, Michael Rice, Melissa Sandercock, Peter Sharley

Road Safety

Chair: Dr William Heddle
Secretariat: Mr Joe Hooper and Ms Claudia Baccanello
Members: A/Prof Robert Atkinson, Drs Bill Geyer, Philip Harding, Stephen Holmes, Patricia Montanaro and Monika Moy

Historical Committee

Chair: Dr Trevor Pickering
Secretariat: Mr Joe Hooper, Ms Claudia Baccanello and Miss Lisa Baker
Members: Drs Dorothea Limmer and Jeanette Linn

AMA(SA) Executive Board

Chair: Dr Trevor Mudge
Secretariat: Mr Joe Hooper and Ms Claudia Baccanello
Members: Drs Margaret Cowling, Janice Fletcher, Patricia Montanaro, Peter Sharley, William Tam and Mr John McLaren.

Federal AMA Committees | AMA(SA) Members

January – December 2013

Audit and Risk Committee

Dr Peter Ford – until May; Dr Peter Sharley – from June

Finance Committee

Dr Peter Ford (Chair) – until May; Dr Andrew Lavender – until May; Dr Peter Sharley – from June

AMA Therapeutics Committee

Dr Peter Sharley – until July

Economics and Workforce Committee

Dr Peter Ford – until May; Dr Patricia Montanaro – from June

AMA Rural Medical Committee

Dr Nigel Stewart – from June

AMA Council of Salaried Doctors

Dr Andrew Russell

AMA Taskforce on Indigenous Health

Dr Peter Sharley – until May

AMA Council of Doctors-in-Training

Dr Andrew Shepherd

AMA Council of General Practice

Dr Patricia Montanaro and Dr Chris Clohesy

AMA National Disability/ Injury Insurance Scheme Taskforce

Dr Patricia Montanaro and Dr James Rice

Corporate Governance

The affairs relating to issues affecting members of the Association and public policy of the Association are controlled by the Council.

It is the duty of Council to carry out the purpose and objects of the Association as laid down by members in accordance with the AMA(SA) Rules, statute and the Constitution of the Federal AMA; and to preserve, maintain promote and advance the interest of Members.

The affairs of the Association that relate directly to the internal corporate governance of the Association and as may be prescribed in the bylaws shall be managed by the Executive Board of Management ('the Executive Board'). The roles of the Executive Board include:

- overseeing the existence and maintenance of internal controls and accounting systems;
- development of the annual budget and operating plan;
- review of the Association's monthly financial statements and performance against budget;
- review of annual statutory financial statements and recommendations for approval by the Council;
- review of major capital expenditure and finance arrangements;
- participation in the review of the remuneration of the Chief Executive Officer;
- provision of general financial advice to the Association; and
- review of the external audit arrangements.

Both Council and the Executive Board may delegate powers to committees or the Chief Executive Officer for the purposes of meeting their obligations as described under the Rules and By laws of the Association.

Membership of Council and the Executive Board is determined in accordance with the Rules of the Association.

The position of Chief Executive Officer is a full-time salaried position which reports to the Board and to Council. The Chief Executive Officer is delegated with the day-to-day management of the Association.

From the Board Chair

Dr Trevor Mudge
Chair, AMA(SA) Executive Board

The Executive Board met monthly in 2013 and is about to complete operations in its first full financial year, having initially met in January of 2013. As a Board we are settling in to a cohesive and co-operative body, and are working well as a team. Progress has been made in many areas, but much remains to be done as we look to how the Association can further strengthen its position and service to members.

Financial report

I am pleased to present the 2013 financial report for members' information (pages 17-22). The AMA(SA) remains in a stable financial position with a recorded overall surplus of $59,563 at the end of December 2013. This compares with a surplus of $171,266 recorded in 2012. Whilst this is a positive result, it is important that the AMA(SA) continues to explore further opportunities to increase the Association's revenue, to reduce our reliance on subscription income, and allow growth in member benefits and services to encourage increased membership.

Branch income

Branch income for the year totalled $1,374,869. This amounted to 2.7% more than budget and was up 7.0% from 2012, mainly due to increased revenue from member subscriptions, advertising, increased preferred providers, commissions and increased numbers for the Gala Dinner in the second quarter of the year.

Branch expenses

Branch expenses for the year totalled $1,315,306. This amounted to 1.5% less than budget and was up 15.8% compared to 2012 as a result of additional costs in entertainment, travel and accommodation due to additional participants at National Conference, increases to land tax, consultant fees for the Newland House re-development, salaries and benefits due to some salary increases and staff being employed for a full year and not part-year as in 2012, staff training related to Board members' AICD and media training, and the Gala Dinner.

Sapmea

Our strategic partnership with Sapmea is progressing. The latter have sold on their conference business Sapro and have moved into AMA House. The AMA Board will be working with Sapmea to strengthen the partnership. It is anticipated that the AMA(SA) will develop future joint venture commercial arrangements as a result of this partnership. Reputational strengths exist for both organisations of course and Sapmea's not-for-profit status has commercial and other benefits, whilst the AMA(SA) is in a position to provide strategic and executive resources.

Building

How best to secure our future accommodation has remained a focus for the Board. Progress has been slow here as it is important to assess the options in sufficient depth to make recommendations to Council whilst minimising calls on our financial resources. It is important that we maximise the value of our real estate holdings into the future. The Board continues to seek advice on this and will report options to Council in advance of any decisions it needs to make

Registered Training Organization

AMA(SA) Training Services is undergoing national accreditation. This is a very important undertaking and has taken up a great deal of time and energy. There will be some further investment required before this venture shows a profit but the Board is confident of its future.

Membership

The Board has placed the issue of membership as a regular agenda item and we have been discussing the full range of issues. We are particularly cognisant of the importance of attracting our young doctors into the Association. The Board met with some members of the Doctors in Training Committee and we have taken up their suggestions to increase our relevance and presence amongst this demographic. The Board will continue to develop its membership strategy as a priority item.

MOORE STEPHENS
ACCOUNTANTS & ADVISORS

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF

AUSTRALIAN MEDICAL ASSOCIATION (SA) INC.

Report on the Financial Report

We have audited the accompanying financial report of Australian Medical Association (SA) Inc., which comprises the statement of financial position as at 31 December 2013, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the period then ended, notes comprising a summary of significant accounting policies and other explanatory information and the statement by officers of the association.

Council's Responsibility for the Financial Report

The Council of the association are responsible for the preparation of the financial report that gives a true and fair view in accordance with Australian Accounting Standards – Reduced Disclosure Requirements (including Australian Accounting Interpretations) and the Associations Incorporation Act (SA) 1985 and for such internal control as the Council determine is necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the financial report based on our audit. We conducted our audit in accordance with Australian Auditing Standards. Those standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance about whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation of the financial report that gives a true and fair view in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the directors, as well as evaluating the overall presentation of the financial report.

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

Independence

In conducting our audit, we have complied with the independence requirements of Australian professional ethical pronouncements.

Opinion

In our opinion, the financial report of Australian Medical Association (SA) Inc. is in accordance with the Associations Incorporations Act (SA) 1985, including:

a) giving a true and fair view of the association's financial position as at 31 December 2013 and of its performance for the period ended on that date; and

b) complying with Australian Accounting Standards – Reduced Disclosure Requirements (including Australian Accounting Interpretations) and the Associations Incorporations Act (SA) 1985.

MOORE STEPHENS ASSURANCE ADELAIDE PTY LTD
ACCOUNTANTS & ADVISORS

JIM GOUSKOS
DIRECTOR
ADELAIDE
Dated, this 24 **day of** March **2014**

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STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 DECEMBER 2013	Note	2013 $	2012 $
Revenue	2	1,374,869	1,338,724
		1,374,869	1,338,724
Employee benefits expense		(628,498)	(530,094)
Depreciation and amortisation expenses		(21,391)	(14,951)
Advertising		-	(11,400)
Rates and taxes		(98,836)	(80,974)
Presidential allowance		(53,220)	(53,220)
Printing and stationery		(8,100)	(10,616)
Insurance		(10,040)	(9,098)
Postage		(5,802)	(4,718)
Repairs and maintenance		(10,497)	(8,745)
Strata Levy		(62,543)	(65,262)
Telephone		(16,263)	(13,383)
Other expenses from ordinary activities	3	(260,684)	(237,723)
Legal fees		(3,813)	(9,240)
Donation		(10,300)	(10,000)
Gala Dinner expense		(80,617)	(53,947)
RTO consulting expense		(30,882)	-
Prizes/Awards		(400)	(2,000)
Profit before income tax		72,983	223,353
Income tax expense / benefit	4	(13,420)	(52,087)
Profit for the year		59,563	171,266
Other comprehensive income			
Net gain on revaluation of building		-	
Other comprehensive income for the year, net of tax		-	-
Total comprehensive income for the year		59,563	171,266
Total comprehensive income attributable to members of the entity		59,563	171,266

STATEMENT OF FINANCIAL POSITION AS AT 31 DECEMBER 2013	Note	2013 $	2012 $
ASSETS			
Current assets			
Cash and cash equivalents	6	753,895	613,980
Trade and other receivables	7	48,371	21,620
Other current assets	8	24,978	7,931
Total Current Assets		827,244	643,531
Non-current assets			
Property, plant and equipment	9	4,085,784	4,082,915
Deferred tax assets	14	268,722	282,142
Total Non-Current Assets		4,354,506	4,365,057
TOTAL ASSETS		5,181,750	5,008,588
LIABILITIES			
Current liabilities			
Trade and other payables	10	714,567	583,946
Finance Lease liabilities	12	8,085	-
Other current liabilities	11	12,800	44,704
Total Current Liabilities		735,452	628,650
Non-current liabilities			
Long-term employee benefits	13	21,604	14,807
Deferred tax liabilities	14	317,250	317,250
Total Non-Current Liabilities		338,854	332,057
TOTAL LIABILITIES		1,074,306	960,707
NET ASSETS		4,107,444	4,047,881
EQUITY			
Reserves	16	990,705	991,105
Retained earnings		3,116,739	3,056,776
TOTAL EQUITY		4,107,444	4,047,881

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 DECEMBER 2013	Retained Earnings $	Reserves $	Total $
Balance at 1 January 2012	2,903,219	973,396	3,876,615
Total comprehensive income for the year			
Profit attributable to members of the entity	171,266	-	171,266
Other comprehensive income for the year			
Fund movements	(17,709)	17,709	0
Total other comprehensive income for the year	(17,709)	17,709	0
Total comprehensive income for the year	153,557	17,709	171,266
Balance at 31 December 2012	3,056,776	991,105	4,047,881
Balance at January 2013	3,056,776	991,105	4,047,881
Total comprehensive income for the year			
Profit attributable to members of the entity	59,563	-	59,563
Other comprehensive income for the year			
Fund movements	400	(400)	-
Total other comprehensive income for the year	400	(400)	-
Total comprehensive income for the year	59,963	(400)	59,563
Balance at 31 December 2013	3,116,739	990,705	4,107,444

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 DECEMBER 2013	Note	2013 $	2012 $
Cash flows from operating activities:			
Receipts from members, tenants and others		1,333,750	1,336,549
Payment to suppliers and employees		(1,204,275)	(1,309,918)
Interest received		14,368	10,756
Income tax paid		13,420	52,087
Net cash provided by operating activities		157,263	89,474
Cash flow from investing activities:			
Purchase of plant and equipment		(25,433)	-
Net cash used in investing activities		(25,433)	-
Cash flow from financing activities:			
Proceeds from borrowings		8,085	-
Net cash (used in)/ provided by financing activities		8,085	-
Net cash increase in cash held		139,915	89,474
Cash and cash equivalents at the beginning of the financial year		613,980	524,506
Cash and cash equivalents at the end of the financial year	6	753,895	613,980

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 DECEMBER 2013

The financial report covers Australian Medical Association (SA) Inc. as an individual entity. Australian Medical Association (SA) Inc. is an association incorporated in South Australia under the Associations Incorporation Act 1985.

NOTE 1 | STATEMENT OF SIGNIFICANT ACCOUNTING POLICIES

Basis of preparation

Australian Medical Association (SA) Inc has elected to early adopt the Australian Accounting Standards - Reduced Disclosure Requirements as set out in AASB 1053: Application of Tiers of Australian Accounting Standards and AASB 2010–2: Accounting Standards arising from Reduced Disclosure Requirements.

The financial statements are general purpose financial statements that have been prepared accordance with Australian Accounting Standards – Reduced Disclosure Requirements of the Australian Accounting Standards Board and the Associations Incorporation Reform Act 2012. The association is a not-for profit entity for financial reporting purposed under Australian Accounting Standard.

Australian Accounting Standards set out accounting policies that the AASB has concluded would result in financial statements containing relevant and reliable information about transactions, events and conditions. Material accounting policies adopted in the preparation of the financial statements are presented below and have been consistently applied unless stated otherwise.

The financial statements except for the cash flow information have been prepared on an accruals basis and are based on historical costs, modified, where applicable, by the measurement at fair value of selected non-current assets, financial assets and financial liabilities. The amounts presented in the financial statements have been rounded to the nearest dollar.

Accounting Policies

(a) Income Tax

The income tax expense (revenue) for the year comprises current income tax expense (income) and deferred tax expense (income).

The charge for current income tax expense is based on the profit for the year adjusted for any non-assessable or disallowed items. It is calculated using the tax rates that have been enacted or are substantially enacted by the balance date.

Deferred tax is accounted for using the balance sheet liability method in respect of temporary differences arising between the tax bases of assets and liabilities and their carrying amounts in the financial statements.

No deferred income tax will be recognised from the initial recognition of an asset or liability, excluding a business combination, where there is no effect on accounting or taxable profit or loss.

Deferred tax is calculated at the tax rates that are expected to apply to the period when the asset is realised or liability is settled. Deferred tax is credited in the income statement except where it relates to items that may be credited directly to equity, in which case the deferred tax is adjusted directly against equity.

Deferred tax assets relating to temporary differences and unused tax losses are recognised to the extent that it is probable that future tax profits will be avaliable against which deductible temporary differences can be utilised.

(a) Income Tax (cont.)
The amount of benefits brought to account or which may be realised in the future is based on the assumption that no adverse change will occur in income taxation legislation and the anticipation that the association will derive sufficient future assessable income to enable the benefit to be realised and comply with the conditions of deductibility imposed by the law. Non-member income of the association is only assessable for tax, as member income is excluded under the principle of mutuality.

(b) Property, Plant and Equipment
Each class of property, plant and equipment is carried at cost or fair value as indicated, less, where applicable, accumulated depreciation and any impairment losses.

Property
Freehold land and buildings are shown at their fair value (being the amount for which an asset could be exchanged between knowledgeable willing parties in an arm's length transaction), based on periodic, but at least triennial, valuations by external independent valuers, less subsequent depreciation for buildings.

Any accumulated depreciation at the date of revaluation is eliminated against the gross carrying amount of the asset and the net amount is restated to the revalued amount of the asset.

Plant and equipment
Plant and equipment are measured on the cost basis and are therefore carried at cost less accumulated depreciation and any accumulated impairment losses.

The carrying amount of plant and equipment is reviewed annually by the committee to ensure it is not in excess of the recoverable amount from these assets. The recoverable amount is assessed on the basis of the expected net cash flows that will be received from the assets' employment and subsequent disposal. The expected net cash flows have been discounted to their present values in determining recoverable amounts.

The cost of fixed assets constructed within the association includes the cost of materials, direct labour, borrowing costs and an appropriate proportion of fixed and variable overheads.

Subsequent costs are included in the asset's carrying amount or recognised as a separate asset, as appropriate, only when it is probable that future economic benefits associated with the item will flow to the association and the cost of the item can be measured reliably. All other repairs and maintenance are charged to the statement of comprehensive income during the financial period in which they are incurred.

Depreciation
The depreciable amount of all fixed assets including buildings and capitalised leased assets, but excluding freehold land, is depreciated over their useful lives to the entity commencing from the time the asset is held ready for use.

The depreciation rates used for each class of depreciable assets are:

Class of Fixed Asset	Depreciation Rates
Furniture and fittings	7.5-20%
Computer equipment	33%

The assets' residual value and useful lives are reviewed, and adjusted if appropriate, at the end of each reporting period.

An asset's carrying amount is written down immediately to its recoverable amount if the asset's carrying amount is greater than its estimated recoverable amount.

Gains and losses on disposals are determined by comparing proceeds with the carrying amount. These gains and losses are included in the statement of comprehensive income. When revalued assets are sold, amounts included in the revaluation relating to that asset are transferred to retained earnings.

(c) Leases
Leases of fixed assets, where substantially all the risks and benefits incidental to the ownership of the asset (but not the legal ownership) are transferred to the association, are classified as finance leases

Finance lease are capitalised by recognising an asset and a liability at the lower of the amount equal to the fair value of the leased property or the present value of the minimum lease payments, including any guaranteed residual values. Lease payments are allocated between the reduction of the lease liability and the lease interest expense for the period.

Leased assets are depreciated on a straight-line basis over their estimated useful lives where it is likely that the association will obtain ownership of the asset or ownership over the term of the lease.

Lease income from operating leases where AMA SA is the lessor is recognised in income on a straight-line basis over the lease term (refer Note 15). The respective leased assets are included in the statement of financial position based on their nature.

(d) Financial Instruments

Initial recognition and measurement
Financial assets and financial liabilities are recognised when the entity becomes a party to the contractual provisions to the instrument. For financial assets, this is equivalent to the date that the association commits itself to either purchase or sell the asset (ie trade date accounting is adopted).

Financial instruments are initially measured at fair value plus transaction costs except where the instrument is classified "at fair value through profit or loss' in which case transaction costs are recognised immediately as expenses in profit or loss

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

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

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

The Association does not designate any interests in subsidiaries, associates or joint venture entities as being subject to the requirements of Accounting Standards specifically applicable to financial instruments.

(i) Financial assets at fair value through profit or loss
Financial assets are classified at "fair value through profit or loss' when they are held for trading for the purpose of short-term profit taking, derivatives not held for hedging purposes, or when they are designated as such to avoid an accounting mismatch or to enable performance evaluation where a group of financial assets is managed by key management personnel on a fair value basis in accordance with a documented risk management or investment strategy. Such assets are subsequently measured at fair value with changes in carrying value being included in profit or loss.

(ii) Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market and are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial asset is derecognised.

Loans and receivables are included in current assets, except for those which are not expected to mature within 12 months after the end of the reporting period, which will be classified as non-current assets.

(iii) Held-to-maturity investments
Held-to-maturity investments are non-derivative financial assets that have fixed maturities and fixed or determinable payments, and it is the Association's intention to hold these investments to maturity. They are subsequently measured at amortised cost using the effective interest rate method. Gains or losses are recognised in profit or loss through the amortisation process and when the financial asset is derecognised.

Held-to-maturity investments are included in non-current assets, except for those which are expected to mature within 12 months after the end of the reporting period, which will be classified as current assets.

If during the period the association sold or reclassified more than an insignificant amount of the held-to-maturity investments before maturity, the entire category of held-to-maturity investments would be tainted and would be reclassified as available-for-sale.

(iv) Available-for-sale investment
Available-for-sale investment are non-derivative financial assets that are either not capable of being classified into other categories of financial assets due to their nature or they are designated as such by management. They comprise investments in the equity of other entities where there is neither a fixed maturity nor fixed or determinable payments.

Available-for-sale financial assets are classified as non-current assets when they are expected to be sold within 12 months after the end of the reporting period. All other available-for-sale financial assets are classified as current assets.

(v) Financial liabilities
Non-derivative financial liabilities (excluding financial guarantees) are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial liability is derecognised.

Fair value
Fair value is determined based on current bid prices for all quoted investments. Valuation techniques are applied to determine the fair value for all unlisted securities, including recent arm's length transactions, reference to similar instruments and option pricing models.

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

In the case of available-for-sale financial assets, a significant or prolonged decline in the market value of the instrument is considered to constitute a loss event. Impairment losses are recognised in profit or loss immediately. Also, any cumulative decline in fair value previously recognised in other comprehensive income is reclassified into profit or loss at this point.

In the case of financial assets carried at amortised cost, loss events may include: indications that the debtors or a group of debtors are experiencing significant financial difficulty, default or delinquency in interest or principal payments; indications that they will enter bankruptcy or other financial reorganisation; and changes in arrears or economic conditions that correlate with defaults.

When the terms of financial assets that would otherwise have been past due or impaired have been renegotiated, the association recognises the impairment for such financial assets by taking into account the original terms as if the terms have not been renegotiated so that the loss events that have occurred are duly considered.

Derecognition
Financial assets are derecognised where the contractual right to receipt of cash flows expires or the asset is transferred to another party whereby the entity no longer has any significant continuing involvement in the risks and benefits associated with the asset. Financial liabilities are derecognised where the related obligations are either discharged, cancelled or expire. The difference between the carrying amount of the financial liability extinguished or transferred to another party and the fair value of consideration paid, including the transfer of non-cash assets or liabilities assumed, is recognised in profit or loss.

(e) Impairment of Assets
At the end of each reporting period, the association assesses whether there is any indication that an asset may be impaired. If such an indication exists, an impairment test is carried out on the asset by comparing the recoverable amount of the asset, being the higher of the asset's fair value less costs to sell and value in use, to the asset's carrying amount. Any excess of the asset's carrying amount over its recoverable amount is recognised immediately in profit or loss, unless the asset is carried at a revalued amount in accordance with another Standard (eg in accordance with the revaluation model in AASB 116). Any impairment loss of a revalued asset is treated as a revaluation decrease in accordance with that other Standard.

Where it is not possible to estimate the recoverable amount of an individual asset, the Association estimates the recoverable amount of the cash-generating unit to which the asset belongs.

Where the future economic benefits of the asset are not primarily dependent upon the asset's ability to generate net cash inflows and when the entity would, if deprived of the asset, replace its remaining future economic benefits, value in use is determined as the depreciated replacement cost of an asset.

Where an impairment loss on a revalued asset is identified, this is recognised against the revaluation surplus in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation surplus for that class of asset.

(f) Employee Benefits
Provision is made for the Association's liability for employee benefits arising from services rendered by employees to balance date. Employee benefits expected to be settled within one year have been measured at the amounts expected to be paid when the liability is settled plus related on-costs. Employee benefits payable later than one year have been measured at the present value of the estimated future cash outflows to be made for those benefits.

Contributions are made by the Association to an employee superannuation fund and are charged as expenses when incurred.

(g) Cash and Cash Equivalents
Cash and cash equivalents include cash on hand, deposits held at call with banks, other short-term highly liquid investments with original maturities of three months or less.

(h) Accounts Receivable and Other Debtors
Accounts receivable and other debtors include amounts due from members as well as amounts receivable from customers for goods sold in the ordinary course of business. Receivables expected to be collected within 12 months of the end of the reporting period are classified as current assets. All other receivables are classified as non-current assets.

Accounts receivable are initially recognised at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment. Refer to Note 1(d) for further discussion on the determination of impairment losses.

(i) Revenue
Revenue from the rendering of services is recognised upon the delivery of the service to the customers.

All revenue is stated net of the amount of goods and services tax (GST).

(j) Comparative Figures
Where required by Accounting Standards, comparative figures have been adjusted to conform with changes in presentation fo the current financial year.

(k) Goods and Services Tax (GST)
Revenues, expenses and assets are recognised net of the amount of GST, except where the amount of GST incurred is not recoverable from the Australian Taxation Office.

(l) Accounts Payable and Other Payables
Accounts payable and other payables represent the liabilities outstanding at the end of the reporting period for goods and services received by the association during the reporting period that remain unpaid. The balance is recognised as a current liability with the amounts normally paid within 30 days of recognition of the liability.

(m) Critical Accounting Estimates and Judgements
Management evaluates estimates and judgements incorporated into the financial statements based on historical knowledge and best available current information. Estimates assume a reasonable expectation of future events and are based on current trends and economic data, obtained both externally and within AMA SA.

Key Estimates – Impairment
The Association assesses impairment at the end of each reporting period by evaluating conditions and events specific to AMA SA that may be indicative of impairment triggers. Recoverable amounts of relevant assets are reassessed using value-in-use calculations which incorporate various key assumptions.

The financial statements were authorised for issue on 20 March 2014 by the Council of the Association.

NOTE 2 | REVENUE

	2013 $	2012 $
Operating Revenue		
- interest	14,368	10,756
- rent	302,559	340,837
- advertising (medical review)	124,827	109,349
- member subscriptions	663,494	624,270
- sundry revenue	166,494	148,348
- gala dinner income	103,127	85,455
- funds received from wind up of Southern Suburbs Medical Association	-	19,709
Total revenue	1,374,869	1,338,724

NOTE 3 | PROFIT FOR THE YEAR

Expenses		
- finance costs	7,233	7,128
Other expenses		
- bad debts	50	(9,675)

NOTE 4 | INCOME TAX EXPENSE

a. The components of tax expense comprise:		
Current tax	13,420	52,087
b. The prima facie tax on profit before income tax is reconciled to the income tax as follows:		
Prima facie tax payable on profit before income tax at 30% (2012: 30%)	22,015	61,693
Less:		
Tax effect of:		
– other non-temporary differences	(7,995)	(21,939)
– Adjustment to opening balance	(600)	12,333
Income tax attributable to the association	13,420	52,087
c. Tax effect relating to other comprehensive income		
Current tax	-	-
Deferred tax	-	-

NOTE 5 | KEY MANAGEMENT PERSONNEL COMPENSATION

The totals of remuneration paid to key management personnel (KMP) of the association during the year are as follows:

Key management personnel compensation	284,146	245,869

Other KMP transactions
For details of other transactions with KMP, refer to Note 18: Related Party Transactions.

NOTE 6 | CASH AND CASH EQUIVALENTS

Cash on hand	300	300
Cash at bank	753,595	613,680
	753,895	613,980

Reconciliation of cash
Cash at the end of the financial year as shown in the Statement of cash flows is reconciled to items in the statement of financial position as follows:

Cash and cash equivalents	753,895	613,980

NOTE 7 | TRADE AND OTHER RECEIVABLES

Trade receivables		50,371	23,620
Less: Provision for doubtful debts	7a	(2,000)	(2,000)
		48,371	21,620

7a. Provision for doubtful debts
Movement in the provision for doubtful debts is as follows:

	Opening balance $ 1 Jan 2012	Charge for the year $	Amounts written off $	Closing balance $ 31 Dec 2012
Current trade receivables	15,244		13,244	2,000

	Opening balance $ 1 Jan 2013	Charge for the year $	Amounts written off $	Closing balance $ 31 Dec 2013
Current trade receivables	2,000			2,000

		2013 $	2012 $
7b. Financial assets classified as loans and receivables			
Trade and other receivables			
- Total current		48,371	21,620
- Total non-current		-	-
		48,371	21,620
Financial assets	18	48,371	21,620

NOTE 8 | OTHER CURRENT ASSETS

Prepayments	24,978	7,931
Other		
	24,978	7,931

NOTE 9 | PROPERTY, PLANT AND EQUIPMENT

Land and Buildings		
Newland House -		
At Independent Valuation 2011	1,480,000	1,480,000
AMA House -		
At Independent Valuation 2011	2,430,000	2,430,000
Total Land and Buildings	3,910,000	3,910,000
Furniture and Equipment		
Branch - at cost	217,423	245,244
less: Accumulated Depreciation	(107,725)	(188,403)
	109,698	56,841
AMA - at cost	7,342	76,430
less: Accumulated Depreciation	(5,125)	(73,356)
	2,217	3,074
Antiques and Paintings - At Valuation	64,539	113,000
less: Accumulated Depreciation	(670)	-
	63,869	113,000
Total Furniture and Equipment	175,784	172,915
Total property, plant and equipment	4,085,784	4,082,915

(a) Movements in Carrying Amounts

	Buildings	Furniture and Equipment	Total
Balance at 1 January 2013	3,910,000	172,915	4,082,915
Additions	-	25,433	25,433
Disposals	-	(1,173)	(1,173)
Depreciation expense	-	(21,391)	(21,391)
Revaluation increments	-	-	-
Carrying amount at 31 December 2013	3,910,000	175,784	4,085,784

NOTE 10 | TRADE AND OTHER PAYABLES

CURRENT		
Unsecured liabilities		
Trade payables	25,488	33,045
Employee benefits	19,244	21,668
Subscription in advance	612,700	468,552
Sundry creditors and accruals	57,135	60,681
	714,567	583,946

a. Financial liabilities at amortised cost classified as trade and other payables

Trade and other payables			
- Total current		714,567	583,946
- Total non-current		-	-
		714,567	583,946
Less subscriptions in advance		(612,700)	(468,552)
Less employee benefits		(19,244)	(21,668)
Financial liabilities as trade and other payables	18	82,623	93,726

Collateral pledged
No collateral has been pledged for any of the trade and other payable balances.

NOTE 11 | OTHER CURRENT LIABILITIES

CURRENT		
Other current liabilities	12,800	44,704

NOTE 12 | LEASE LIABILITIES

	2013 $	2012 $
CURRENT		
HP Lease liability	8,085	-
	8,085	-

NOTE 13 | LONG TERM EMPLOYEE BENEFITS

Long-term employee benefits	21,604	14,807

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

NOTE 14 | TAX

	Opening Balance $	Charge Directly to Equity $	Recognised in Income $	Closing Balance $
NON-CURRENT				
Deferred tax liability				
Fair value gain	317,250	-	-	317,250
Balance at 31 December 2012	317,250	-	-	317,250
Fair value gain	317,250	-	-	317,250
Balance at 31 December 2013	317,250	-	-	317,250
Deferred tax assets				
Provisions	14,923	-	(3,381)	11,542
Deferred expenditure	-	-	2,496	2,496
Carried forward tax losses	319,306	-	(51,202)	268,104
Balance at 31 December 2012	334,229	-	(52,087)	282,142
Provisions	11,542	-	2,328	13,870
Deferred expenditure	2,496	-	(544)	1,952
Carried forward tax losses	268,104	-	(15,204)	252,900
Balance at 31 December 2013	282,142	-	(13,420)	268,722

NOTE 15 | CAPITAL AND LEASING COMMITMENTS

a. Finance lease Commitments		
Payable - minimum lease payments		
- no later than 12 months	6,672	-
- between 12 months and five years	2,223	-
- later than five years		-
	8,895	-
Minimum lease payments	8,895	-
Less future finance charges	(810)	
Present value of minimum lease payments	8,085	-

b. Operating Lease Commitments
Leases as Lessor
Minimum lease payments under non-cancellable operating leases of property held (see Note 9) not recognised in the financial statements are receivable as follows:

within one year	316,977	322,963
between 1 and 5 years	896,907	204,162
	1,213,884	527,125

NOTE 16 | RESERVES

Asset Revaluation Reserve (a)	950,950	950,950
De Crespigny Memorial Fund (b)	3,468	3,668
Listerian Oration Fund (c)	3,662	3,662
Frank S Hone Memorial Fund (d)	12,916	13,116
Southern Suburbs Medical Association (e)	19,709	19,709
	990,705	991,105

(a) Asset Revaluation Reserve

Movements during the financial year:		
Opening balance	950,950	950,950
Revaluation of building	-	
Closing Balance	950,950	950,950

The asset revaluation reserve records revaluations of non-current assets

(b) De Crespigny Memorial Fund Movements during the financial year:	2013 $	2012 $
Opening balance	3,668	4,668
University of Adelaide - Awards 2012	(200)	(1,000)
Closing Balance	3,468	3,668

The De Crespigny Memorial Fund records funds held for the annual provision of a prize award to the student at The University of Adelaide who, at the final examination for the degrees of Bachelor of Medicine and Bachelor of Surgery, gains the highest marks in the clinical section of the subject medicine.

(c) Listerian Oration Fund Movements during the financial year:		
Opening balance	3,662	3,662
Interest	-	-
Closing Balance	3,662	3,662

The Listerian Oration Fund records funds held for the Listerian Oration.

(d) Frank S Hone Memorial Fund Movements during the financial year:		
Opening balance	13,116	14,116
University of Adelaide - Awards 2012	(200)	(1,000)
Closing Balance	12,916	13,116

The Frank S Hone Memorial Fund records funds held for the annual provision of a prize award to the candidate at The University of Adelaide who, in passing the final examination for the degrees of Bachelor of Medicine and Bachelor of Surgery, attains the highest marks in that section which relates to the subject Medicine.

(e) Association Reserve Movements during the financial year:		
Opening balance	19,709	19,709
Transfers from retained earnings	-	-
Closing Balance	19,709	19,709

Purpose: Funds specially set aside to assist other medical associations.

NOTE 17 | RELATED PARTY TRANSACTIONS

Transactions between related parties are on normal commercial terms and conditions and no more favourable than those available to other parties unless otherwise stated.

NOTE 18 | FINANCIAL RISK MANAGEMENT

Australian Medical Association (SA) Inc.'s financial instruments consist mainly of deposits with banks, local money market instruments and loans.

The Association's financial instruments consist mainly of deposits with banks, local money market instruments, short-term investments, accounts receivable and payable, and leases.

The totals for each category of financial instruments, measured in accordance with AASB 139 as detailed in the accounting policies to these financial statements, are as follows:

Financial assets		
Cash and cash equivalents	753,895	613,980
Loans and receivables	48,371	21,620
Total financial assets	802,266	635,600
Financial liabilities		
Financial liabilities at amortised cost:		
– trade and other payables	82,623	93,726
– borrowings	-	-
Total financial liabilities	82,623	93,726

NOTE 19 | EVENTS AFTER THE REPORTING PERIOD

No matters or circumstances have arisen since the end of the financial year which significantly affected or may significantly affect the operations of the entity, the results of those operations, or the state of affairs of the entity in future financial years.

NOTE 20 | CONTINGENT LIABILITIES

There were no contingent liabilities for Australian Medical Association (SA) Inc. at balance date.

NOTE 21 | ASSOCIATION DETAILS

The principal place of business is:
Australian Medical Association (SA) Inc.
80 Brougham Place
NORTH ADELAIDE SA 5006

Report of the Councillors

In accordance with section 35(5) of the Associations Incorporation Act, (SA) 1985, the Council of Australian Medical Association (SA) Inc hereby states that during the financial year ended 31 December 2013:-

(a) (1) no officer of Australian Medical Association (SA) Inc.

(2) no firm of which an officer is a member; and

(3) no body corporate in which an officer has a substantial financial interest,

has received or become entitled to receive a benefit as a result of a contract between the officer, firm or body corporate and Australian Medical Association (SA) Inc. except for the following:

- The President of the Australian Medical Association (SA) Inc. receives an allowance in carrying out duties on behalf of the Association. During 2013 there were two Presidents and the amount paid to Dr P Sharley for the period 1/1/2013 to 15/04/2013 was $17,740 and the amount paid to Dr P Montanaro for the period 16/04/2013 to 31/12/2013 was $35,480.

- The Australian Medical Association (SA) Inc. engaged McLaren Consulting Pty Ltd on normal commercial terms and conditions during the year for $3,500 for professional services relating to branding and communication strategy development. Mr John McLaren is a Director and shareholder of McLaren Consulting Pty Ltd and also a Council member of the Australian Medical Association (SA) Inc.

(b) no officer of the Australian Medical Association (SA) Inc. has received directly or indirectly from the Association any payment or other benefit of a pecuniary value.

Statement by Officers of the Association

In the opinion of the Councillors of the association the financial report as set out on pages 17 to 22:

(a) Presents a true and fair view of the financial position of Australian Medical Association (SA) Inc. as at 31 December 2013 and its performance for the year ended on that date in accordance with Australian Accounting Standards (including Australian Accounting Interpretations) of the Australian Accounting Standards Board.

(b) At the date of this statement there are reasonable grounds to believe that Australian Medical Association (SA) Inc. will be able to pay its debts as and when they fall due.

This statement is made in accordance with a resolution of the Council and is signed for and on behalf of the Council by:

Board Chairperson: .....

Board Member: .....

Dated this 20 March 2014

AMA
SOUTH AUSTRALIA

Australian Medical Association (South Australia) Inc.

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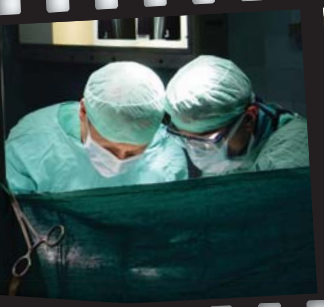

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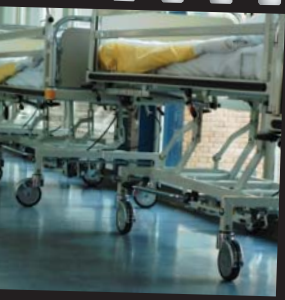



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