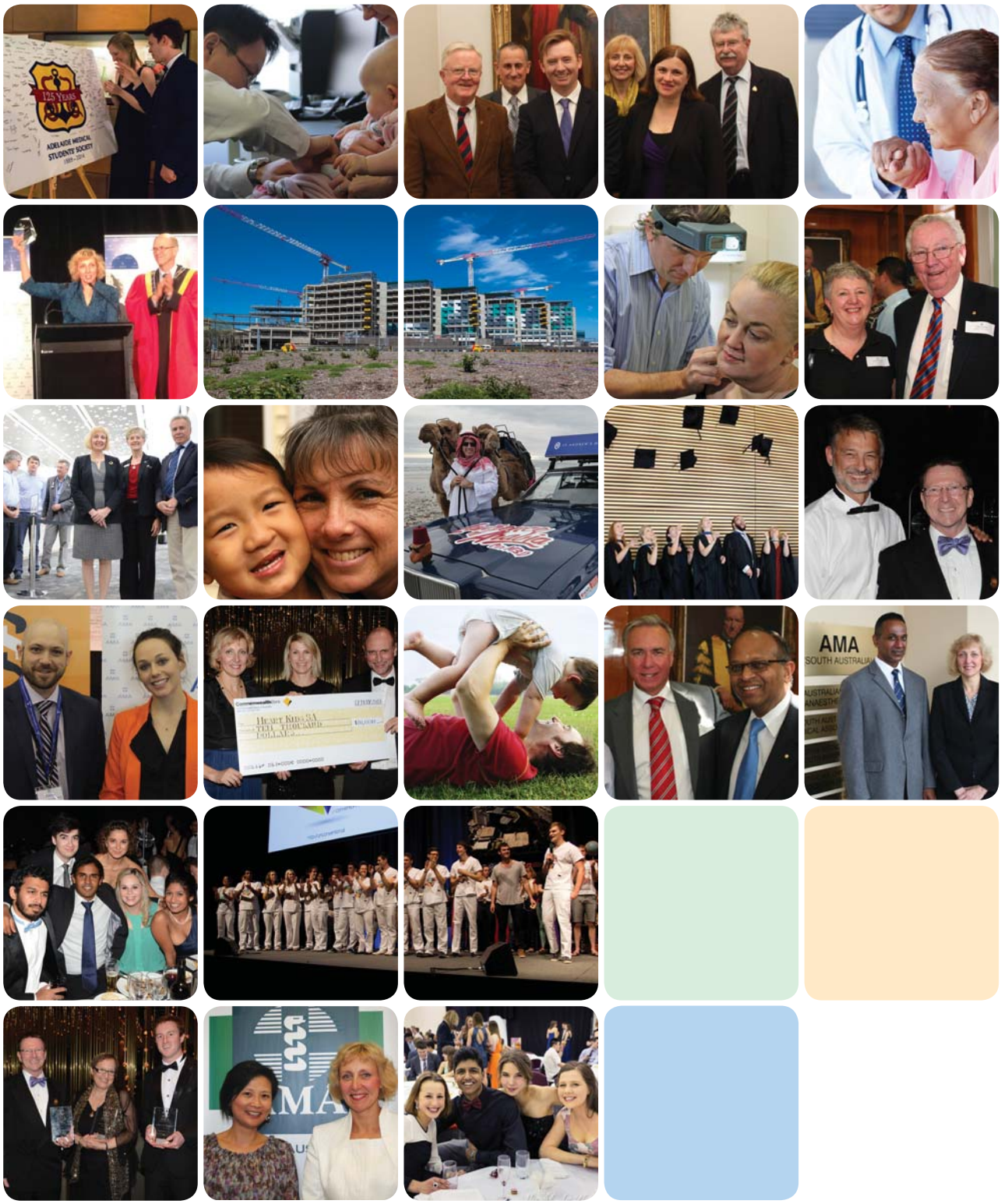
Australian Medical Association (South Australia) Inc.

AMA
SOUTH AUSTRALIA

Annual Report 2014



AMA(SA) Council

Membership of Council January – December 2014

Position on Council	
President:	Dr Patricia Montanaro (9)
Vice President:	Dr Janice Fletcher (6)
Immediate Past President:	Dr Peter Sharley (6)
Co-Chairs:	Dr David Walsh (8)
	Dr Janice Fletcher (6)
Federal Councillors	
State Nominee:	Dr Patricia Montanaro (9)
Area Nominee SA/NT:	Dr Christopher Moy (6)
Craft Group Nominee: Surgeons:	Dr Susan Neuhaus (0)
Craft Group Representatives	
Anaesthetists:	Dr Margaret Cowling (9)
Emergency Medicine:	Dr Hendrika Meyer-Jones (6)
General Practitioners:	Dr Christopher Clohesy (7)
Obstetricians and Gynaecologists:	Dr Stephen Lane (5)
Pathologists:	Dr Heather Cain (7)
Physicians:	A/Prof William Tam (7)
Psychiatrists:	Dr Michelle Atchison (9)
Radiologists:	Dr Nicholas Rice (8)
Surgeons:	Dr David Walsh (8)
Paediatricians:	Dr Andrew Kelly (4)
Doctors in Training Representatives	Dr Andrew Shepherd – to May 2014 (0)
	Dr Thomas Crowhurst – from June 2014 (5)
Medical Students' Representatives	
Adelaide:	Ms Alyssa Parsons (6)
Flinders:	Mr Nick Stock (8)
Ordinary Members of Council	Dr Susan Baillie – to May 2014 (1)
	Dr Tarun Bastiampillai – from June 2014 (2)
	Dr Peter Ford – to May 2014 (4)
	Dr Matthew McConnell – from June 2014 (5)
	Dr Christopher Moy (6)
	Dr Clair Pridmore – from June 2014 (4)
	Dr Emma Rischbieth (5)
	Dr David Sainsbury – from June 2014 (3)
	Dr David Scrimgeour - from June 2014 (3)
	Dr Roger Sexton – to May 2014 (3)
	Dr Stephan Van Eeden – to May 2014 (1)
	Prof Paul Worley – from June 2014 (3)
Regional Representatives	
Northern:	Dr Nigel Stewart – (0) In absentia by agreement
	Dr John Williams (6)
Southern:	Dr Trevor Hodson (3)
	Dr Oluwadare Kuku – to May 2014 (0)
	Dr Peter Tait (0)
Salaried Medical Officers' Representative	Dr Andrew Russell (8)
AMA(SA) Secretariat	
Chief Executive Officer:	Mr Joe Hooper (7)
Minute Secretary:	Ms Claudia Baccanello (9)

Note [1]: numbers indicate attendance at the AMA(SA) Council meetings February - December 2014 (a total of 9 meetings) and include attendance both in person and by teleconference. Note [2]: Following the AGM some Councillors have attended in a different role.

Dr Patricia Montanaro
President, AMA(SA)

From the President

The AMA has seen interesting times in 2014, both at state and national levels.

The federal government created waves of concern with its adverse health budget measures and controversial co-payment plans. The federal budget's effects were reflected in the subsequent state budget, and the state government's response included an initiative to 'transform' the health system – or at least, parts of it – which will no doubt bring more interesting times in 2015.

It has been another very busy year for state-level advocacy, with the AMA(SA) making over 30 submissions this calendar year, including significant pre-election advocacy in the lead-up to the March state election. Topics included the needed Women's and Children's Hospital co-location at the new RAH site, the important role of a Commissioner for Children and Young People, changes to WorkCover, mental health, health system engagement, abolition or reclassifications of various government boards and committees, fitness to drive, advance care directives, various hospital and practice matters, and many more.

We have also highlighted the importance of clinical governance and leadership: an enduring theme in our advocacy. We dare to hope that one day we will no longer need to keep advancing our arguments for improvements in this area, as the message will have been received, and we will be seeing the benefits in a better, more innovative, more responsive, and generally improved health system and services.

A highlight of the year was the release of our *Key Priorities for Health* document in the lead-up to the state election, and a number of opinion pieces in *The Advertiser* around key themes and issues were well received. We also provided informative updates to members on the parties' health policies and their response to our advocacy document. For the historians among you, this information is still available on our website.

On that note, the end of 2014 saw a new and improved AMA(SA) website, together with a new federal AMA website – if you have not yet made use of it – do – there is a range of information and resources from the state and national platforms on many things health-related.

Our views continue to be often sought by government, politicians, the media, and others, and we continue to see that they make a difference. Another public health highlight in 2014 has been ongoing work on anti-gambling health advocacy – a push over the holiday season in 2013, with continuing work in 2014. Our work with the Office for Problem Gambling in this area is another example of how AMA support can make a real difference in helping to get a message out, and make it more effective.

On the national stage, we gained a new federal AMA constitution and a new federal president and vice president, who have ably tackled a complex advocacy arena. Another national highlight was the federal AMA's national alcohol summit – which complemented past SA work and advocacy in this space. Road safety has been another key area, and our SA Road Safety Committee's work will assist federal AMA activity in this area, following much state-level activity around mandatory medical assessments and forms. Also, we participated in an SA Police Road safety video planned to be used for educating school students.

As every year, the AMA(SA) could be found speaking on behalf of the profession and the patients we serve on TV, radio stations, print media and online, across the state and beyond it, on topics from health reform to the wonders of the parathyroid. We also stepped up our member communications with a wide array of news and views communicated via *medicSA*, the Voice, and member updates. Our communications have grown more integrated across media – print, electronic and website, and include significant resource information linked from our website – and more to come. We have provided a wide range of information to members on practice matters such as coroner's findings, consultation on new fitness to drive forms, legislative changes and political news and views.

Linking with other groups has been an important component, and we have flown the flag at a long list of events and functions, formally and informally, engaging with the profession and beyond it.

Rural visits have been a particular highlight – to Clare, Burra, Barmera, Port Augusta, Kangaroo Island, the South East (Mount Gambier, Millicent, Penola, Naracoorte, Bordertown, Keith) and the Riverland (Waikerie, Barmera, Berri and Loxton). We are looking forward to more in 2015. In addition, I was glad to participate in another regular fortnightly 'health spot' on ABC Radio across rural and regional SA and Broken Hill with Afternoons presenter Annette Marner – the 'Top to Toe' segment: a feel-good medical spot with positive health

messages and information about the wonders of the human body and keeping healthy.

The commitment and expertise of our state Council continues to be exemplary and I thank all who have taken up these important roles in 2014, many of whom have contributed to the Association's work over a long period – and in particular Dr Janice Fletcher, our vice president. Much credit must also go to the AMA(SA)'s Executive Board, which continues to do important work on the more operational matters of the AMA(SA)'s function, and future practical offerings to members.

Our Committees also play a very important role, and each deserve special mention. The Historical Committee has been very active, including working on a war memorial book for release next year, cataloguing, and gathering more information on the history of the AMA in South Australia, particularly our past presidents. Our Doctors in Training Committee has been a strong voice for junior doctors, highlighting a range of issues, and our Council of General Practice and Road Safety Committee have been vital voices in their respective fields, informing our work and advocacy. Our Communications Committee performs a vital function in helping us to get key messages out to members and more broadly.

Strategic alliances with sapmea and the AMA(SA) Training initiative have been a big focus in 2014 and show much promise. Building on work done in 2013 and earlier we have a fine collection of medical groups now part of the AMA(SA) family – additions in 2014 include the Salisbury Elizabeth Medical Association, the Australian Chinese Medical Association, and the SA Sri Lankan Doctors Association, added to the Australian Society of Anaesthetists, South Australian Indian Medical Association, Medical Benevolent Association of South Australia and Pakistani Medical Association.

Celebrations were a highlight of the year. We had another very enjoyable charity gala dinner in 2014, with a great crowd of people and $10,000 raised for HeartKids SA. We also had the opportunity there to acknowledge some special people in health with some AMA(SA) Awards: Dr Ruth Marshall, Dr Andrew Lavender and Dr Hugh Kildea.

Our joint Melbourne Cup Lunch with the Law Society of South Australia and Chartered Accountants Australia and New Zealand was again a success, raising funds for a range of charities (Cancer Council SA, The Smith Family and the Hutt Street Centre). Our Retired Members, Life Members and Past Presidents' lunch remains a key event on our calendar, and grows each year. We were also very glad to support the Australian Medical Students Association Convention in Adelaide this year.

The AMA (SA) family keeps growing, and we continue to reach out to our colleagues, members and non-members, and liaise with the colleges and other groups such as the Cancer Council and Law Society, among others.

We continue to assist members on matters great and small, and expand our range of member benefits, with in 2014 the addition of GoodLife Health Clubs. These and other lifestyle benefits complement our practice support, resources and important advocacy work, and we will keep looking at ways to better help members and make your lives easier where we can. We do so with the support of our great staff at the AMA(SA), led by CEO Joe Hooper, and with support from our interstate colleagues in other state AMAs and the federal AMA, with its considerable policy and advocacy work on the national arena. Meeting with leaders in politics, health and other areas at state and national levels, there is indeed much we can, and do, achieve as an organisation.

Of course all of this is for you – our members – and could not be achieved without you. Thank you for your support of the AMA as your voice for the profession – diverse but united.

Joe Hooper
AMA(SA) CEO

From the Chief Executive Officer

2014 presented the AMA(SA) with a range of challenges and opportunities.

Advocacy
The Association has continued to focus its energy on our main role of advocacy. The report on page 7 highlights the significant activity we undertake on behalf of our membership and we should all be very proud of the considerable efforts of our president, Dr Patricia Montanaro and the members of council who provide support and advice.

This year was particularly demanding as we targeted the many issues facing medicine. In particular I wish to highlight our advocacy around the new Royal Adelaide Hospital; the government's attack on special purpose funds and the potential loss of many millions of research dollars to general revenue; the EPAS rollout to some hospital sites and problems that followed; the significant changes to the WorkCover and Motor Accident Commission legislation; and lastly the state election. Without the support of our members, we would not be able to resource the work we have done in these and many other areas – thank you all!

AMA(SA) Training
Aside from advocacy, the AMA(SA) places a priority on assisting members in whatever ways it can. Last year the Executive Board supported investment in AMA(SA) Training, our registered training organisation. Whilst our student growth has not been as strong as we would have liked, we recognise this is not our 'product', but a consequence of state and federal government funding policy that has had a large impact on the vocational education sector.

We realise that governments at both levels will need to review their programs and begin administering education funding in the New Year. The AMA(SA) has been active meeting with the sector and we will be advocating most strongly in the health education landscape. In the meantime we have commenced student enrolments with participants interstate as well as locally. All courses are deliverable 'on line' to promote rural and regional access. Our goal is to offer training and support for all staff working in medical and health practices as well as to assist with future employment opportunities for those undertaking qualifications through AMA(SA) Training. The Board and myself are most grateful to Mrs Kathy Stanton AM and Mrs Michelle Cockshell for their significant assistance in the development of this division of AMA(SA)'s services.

sapmea alliance
Our strategic alliance with sapmea has gone from strength to strength with sapmea moving into AMA House and sharing offices with AMA(SA) Training. The combination of these entities means we have a 'one-stop shop' for members and all medical professionals and staff to undertake accredited college training, nationally accredited VET qualifications, workshops and non-accredited training through a single point of contact.

Membership
Membership has continued to increase with 1612 members December this year against 1584 in end of year 2013. This is a 10% increase from our 2012 membership numbers. This has been encouraging but we must continue to focus on providing value for the profession. The AMA(SA) faces a real challenge in recruiting and retaining our younger doctors. The Board has met with representatives from our doctors in training committee and we are targeting membership in this category. This includes more direct relationships and active engagement at the hospital and university level as well as seeking their opinion on what they want from the AMA(SA).

We are exploring more ways to segment our membership in order that we may address different needs across the membership. Retention of existing members is as important as recruitment and whilst we understand members may 'come and go' according to circumstances, we are not confident we are sufficiently informed of the barriers to membership. We will be undertaking further activities in 2015 to further inform our direction.

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. Whilst we show a small negative balance in our annual financial results of $50,965, our overall end-of-year current asset position $819,175 and total equity $4,266,479 are both improved compared to the 2013 result of $827,244 and $4,107,444 respectively, demonstrating we continue to show an improved financial position overall.

The majority of the loss is our investment in AMA(SA) Training. However this was anticipated and contingency reserves were budgeted against the loss. Whilst returns have been less than projected, we continue to invest in this project as we believe there is a role for the AMA(SA) in training medical support staff as well as providing courses for our members' own professional development. Our member survey conducted in November 2013 strongly supported this role and we believe this is a direct benefit service for members. The Board is naturally conscious of the risks attached to setting up a new organisation as well as the political and economic pressures at this time. The Board will be receiving regular reports on progress and budgets will be reviewed closely over the next year.

Further financial details are contained in the Chairman's report and the audited accounts.

Property
The Association's property management over AMA House had solid rental returns again this year. Whilst we had a small period of untenanted property, all lease options have been exercised. The vacancy in one of our units in AMA(SA) House was quickly re-leased as anticipated in last year's report.

The AMA(SA) Board is examining the use of Newland House. The building represents a significant asset but also some risk for the Association due to its maintenance costs, lack of adequate facilities and structural restrictions. Its ongoing use for office and other functions is not sustainable and the Board must examine alternative options available to ensure members have appropriate accommodation for their future requirements.

Staffing
Our employee FTE numbers remain small (7) and all staff assist across the Association's activities.

In June 2014, we undertook to restructure our employment contract arrangements and entered into a labour service hire agreement with sapmea. This has allowed staff to receive tax benefits, reducing AMA's salary costs moving forward but also provides for sapmea and AMA staff to share services and workload. Staff are expected to provide services across both organisations as required and this provides increased flexibility and staff coverage for both organisations as well as other economies through a shared service arrangement.

As mentioned, Ms Bernadette Liddy was employed on staff in September 2014. Bernadette will be responsible for business development and relationships, including our key preferred partners. Bernadette will also be involved in membership promotion activities.

Appreciations
I would like to acknowledge the work of Dr Patricia Montanaro, who has continued to be an enthusiastic and committed president for the AMA(SA). Her media presence has been very high and the regular radio engagements help promote public recognition of the association across rural South Australia.

I also thank Dr Trevor Mudge in his role as chair of the Executive Board and Dr David Walsh for his chairing of Council. As always we acknowledge with gratitude all councillors for their availability, support and advice that has contributed to the work of the AMA(SA) in 2014.

Finally, I sincerely thank all 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 supporting Council, the Executive Board, the president and myself, the AMA(SA) could not achieve the recognition and respect we are afforded throughout South Australia.

AMA(SA) Advocacy | 2014

Election 2014
After some hanging in doubt a (minority) Labor Government was confirmed, with the support of Independent MP Geoff Brock.

The Labor 'Plan for SA' had a range of health promises and proposals. The Liberal Party too released a range of health policies, and both parties threw in various announcements, at times matching or outmatching each other's promises or, as in the case of the use of the 'old' Royal Adelaide Hospital (RAH) site, presenting very different plans.

The AMA(SA) had its say in its *Key Priorities for Health* document, released in the lead-up to the election in early February. It presented some key areas for attention, drawing on a range of areas of ongoing AMA(SA) advocacy. In particular, we looked at access issues; system improvement; children and young people; workforce, training and research; a master plan for SA's Health and Biomedical Precinct; prevention and promotion; public hospitals; and mental health.

The issues and solutions we proposed take a long-term view that is about much more than just election season but the months and years to come, and will provide a strong platform for our ongoing advocacy. We sent it to all members of Parliament and requested a formal response from both the Labor and Liberal Parties prior to the election, and received a response from the Australian Greens also. These were reported in our members' newsletter The Voice in the election lead-up and published on our website, where you can find them still.

The Health Minister Jack Snelling and Shadow Health Minister Rob Lucas also presented to AMA(SA) Council in the lead-up to the election, giving us a taste of what they would offer for health. Both were returned to their roles post-election, with Mr Lucas gaining the Shadow Ministry of Mental Health and Substance Abuse from Dr Duncan McFetridge, as well as Suicide Prevention.

State Budget
The theme for health for this year's state budget was very much about the response to the federal government's budget cuts to health spending. The SA Treasurer warned South Australians that not only was the news bad, the cuts would be passed on, and they would hurt.

The state government put the health funding reductions for SA at $655 million over the forward estimates but further put the reduction in National Health Reform payments at more than $4.7 billion across the next 10 years compared to the Commonwealth's 2013–14 Mid-Year Economic and Fiscal Outlook.

In response the SA state government proposed savings of $332 million to our healthcare system over four years and the removal of Emergency Services Levy remissions to cover the remainder of the $655 million.

The state government also proposed to 'reassess' areas of capital expenditure, suspending stage three of the upgrade planned for The Queen Elizabeth Hospital ($125 million) as well as planned upgrades at Modbury ($27.8), and Noarlunga ($31.3). Also on hold is the $100 million pre-election commitment to redevelop Flinders Medical Centre (but with the neonatal development still to go ahead). The held funds have been redirected into a Health Capital Reconfiguration Fund. How it will be spent remains to be seen, but is meant to complement outcomes of a system review.

SA Treasurer Tom Koutsantonis told *The Australian* that in view of federal cuts "it is not prudent to be spending on infrastructure that increases your capacity at some hospitals, when you may have to actually decrease capacity on the basis of the cuts." In terms of the cuts and longer term repercussions, the Health Minister, Jack Snelling, said that he would consult with key groups on what could be done and how, indicating that the health system has to be reconfigured.

The AMA(SA)'s key messages remain what they have always been: that our system can be improved – for example through better supporting the things that keep people out of more expensive care, disease prevention and health promotion, and the right balance of acute, primary and step-down and community services; and through working smarter, such as through better co-ordination across services, reduced red tape and bureaucracy, and the gains that support of clinical governance can bring. Also that consultation must be genuine; that blame-shifting and cost-shifting don't work; and that our patients and our communities deserve the best health system we can deliver.

Transforming Health
This year's federal budget presented some bad news for health – there were big cuts coming to health spending. Three Ministerial advisory groups (medical, nursing and midwifery, and allied and scientific health) were set up; a 'Transforming Health' discussion paper (including 282 proposed clinical standards) was released in October; and a full-day summit was held in November attended by around 600 health professionals and community members.

The AMA(SA)'s stance has been that the full impact of any changes to our health system must be carefully considered, after full community and clinical consultation. Transforming public metropolitan hospitals is only part of the answer. We need to look at health across the whole system and state. This includes the vital work that occurs in general practice and the community, private health, rehabilitation and step-down facilities, mental health, prevention and health promotion, as well as the aged care and disability sectors.

Throughout October and November, AMA(SA) president Dr Patricia Montanaro spoke to a range of news channels about the state government's ambitious plan to overhaul the health system. She stressed that any changes need to be about quality; that what we don't want is a reform shaped to fit the cuts and sold to the community as improvements in our system.

The Association sought feedback on the Transforming Health discussion paper from its State Council and the specialist medical colleges as well as its broader membership. We provided an extensive submission to government, now available on our website, and summarised in the supplement available with the April 2015 issue of *medicSA* .

New RAH
With an open date in 2016, much needs to occur to have the new RAH ready, and time is short. The AMA(SA) continued to express its concern at the ongoing lack of detail and information available.

Until we know what services will be there, all the issues of workforce planning, clinical delivery systems, transport logistics, staff training, final service relocations and patient flow remain uncertain. Until more detail is provided, there will be ongoing challenges for the government in managing public and clinicians' expectations on this major infrastructure spend, conceived as the flagship of the health system in South Australia.

Needless to say, the new RAH is a critical project, and the process of transition must support the necessary feedback, dialogue and discussions, to ensure that what can be learned is learned – sooner rather than later. The fact that services are provided by people, not buildings, and that health care is a complex, clinically and technically nuanced continuum must be enshrined in all aspects of the project.

The new RAH presents a bold plan but all bold plans have risks. To succeed, it needs to bring people with it. A hospital is not a house for medicine, it's a hive, and to succeed it will have to bring its workers, its doctors, nurses and other health professionals with it. It will also have to engage the community in its promise of a better way. We all want a great hospital: how to get there from here must be a team effort.

Relocation of WCH to biomedical precinct
The AMA(SA) advocated for the move of the Women's and Children's Hospital (WCH) to the new RAH site, saying there were significant benefits of having the major medical facilities in close proximity. The WCH must also retain its individual identity and entrance.

GP co-payment
The federal government's budget proposal for a general practice co-payment was universally condemned from the moment it was announced.

At the request of the Prime Minister, the AMA developed and released an alternative co-payment model, aiming to protect vulnerable groups in our community while suggesting that, where people can afford to contribute, they should do so.

On the release of the model in late August, federal AMA president A/Prof Brian Owler called on the government to dump its seriously flawed GP co-payments proposal and adopt the AMA model, which exempts the most vulnerable patients from extra cost burdens for their health care.

Special Purpose Funds
After many months of strong lobbying, the AMA(SA) was successful in convincing the government to reverse its blanket decision to restrict access to the many Special Purpose Funds (SPFs) that support medical research and teaching in this state.

SPFs play a significant role in providing many important medical activities in our public hospitals, with funds going towards vital research, funding research scientists, PhD scholarships, research assistants and nurses, specialised medical equipment and other necessary resources.

Emergency department waits
A national report on emergency department waits released in May found national improvement – but not in SA. Dr Montanaro discussed the NEAT target results in the media, saying that with funding reductions announced it's hard to see that we would meet these targets.

AMA(SA) spreads the word about road safety
SA Police invited the AMA(SA) to help spread the word about road safety through supporting its road safety sessions, presented in schools across the state in partnership with the Motor Accident Commission.

The sessions are delivered by SA Police's Road Safety Section, which designed a new session based on a fatal car crash involving a young male driver which occurred in South Australia in 2012. The theme of the session is the choices, risks and consequences involved with driving a motor vehicle related to the fatal five causes of crashes (drink and drug driving, speeding, seat-belts, distractions whilst driving and dangerous driving).

To help highlight the science behind the risks, SA Police sought the AMA's support to present the stark facts around the use of alcohol and drugs

and driving from the perspective of the medical profession.

Fitness to drive
Mandatory medicals for drivers aged over 70 ceased from 1 September 2014, while a new interim fitness to drive form was implemented. Both changes came about in response to AMA concerns.

The AMA(SA) welcomed the announcement from the state government that SA drivers over the age of 70 no longer have to have mandatory drivers licence medical testing each year for their licence as a victory for common sense.

The AMA(SA) lobbied for this change, highlighting that the age of 70 is not necessarily a threshold factor for cognitive and motor skill decline and impairment. Doctors are able to assess their patients' capacity at any stage of their continuum of life in accordance with the road safety clinical guidelines.

In response to the AMA(SA)'s concerns, the Department of Planning, Transport and Infrastructure implemented a new interim fitness to drive form. The AMA(SA) provided feedback from members to help improve the form which was originally introduced in 2013.

Rural practice GP Agreement
A base GP Agreement in SA public country hospitals has been distributed to rural general practitioners by Country Health SA. This was the result of several months of protracted negotiations between Country Health SA, the AMA(SA) and the Rural Doctors' Association (SA).

The AMA(SA) did not endorse the current document but agreed to the release of the new Agreement in order to allow its members to commence further negotiations.

The new Agreement provided no reduction, and some improvements, in the terms and conditions of the existing Agreement that expired on 30 November 2014.

Importantly, the AMA(SA) negotiated a new process to assist GPs who have limited capacity to provide inpatient services and the required number of on-call rosters. The alternate models of engagement will potentially allow for more rural GPs to continue contributing to rural hospital services whilst maintaining their busy practices. The AMA(SA) believes this provision will be attractive to a large number of our members.

Other improvements include further clarification of terms to reduce ambiguity around fees and service expectations and improved billing for road traffic injuries via a third party arrangement.

Rural visits
The AMA(SA) visited a number of rural areas throughout the state in 2014, including the South East in June, the Murray Mallee region in September, and the Riverland region in late October, in order to give doctors in the region the opportunity to discuss relevant issues directly with president Dr Patricia Montanaro and CEO Mr Joe Hooper.

Common themes emerged from their meetings with local doctors, including issues around the impact of the government's GP co-payment fee; the sustainability of the health system, in rural areas in particular; and attracting and maintaining suitably skilled staff. They also emphasised the importance of the Patient Assistance Transport Scheme, expressing their concerns about funding and wanted clarity around changes in government policy.

They also wanted to make sure the health system was sustainable, suitably skilled and prepared to deal with the devastating effects of unemployment or natural disasters on their patients.

Dr Montanaro criticised the federal government for what she saw as its failure to provide enough health funding, and also said that buck-passing between levels of government and departments within SA Health needed to stop.

She also emphasised the importance of encouraging country students to study medicine.

Doctors in training
The AMA(SA) Doctors-in-Training Committee has advocated for a fair and efficient process for the allocation of junior doctor jobs as well as emphasising the importance of high-quality medical training for junior doctors, including in prevocational jobs. In 2014, the Committee has attempted to ensure that all South Australian medical graduates obtain high-quality internships, particularly in the context of recent Federal cuts to the Prevocational General Practice Placement Program. It has also focused on ensuring there is meaningful independent junior doctor input into both the new RAH and the Enterprise Patient Administration System. Other priorities for the Committee included protecting the positive culture within the junior doctor community and ensuring safe and appropriate working conditions are maintained.

EPAS
EPAS (the Enterprise Patient Administration System) has been rolled out throughout 2014. It started with hospitals in Port Augusta and Mount Gambier, and the Repatriation General Hospital. Next in line – SA metropolitan public hospitals, GP Plus Centres, GP Super Clinics and SA Ambulance headquarters. The AMA(SA) has kept a close watch as the system is rolled out.

It is an expensive undertaking ($422 million plus across the next 10 years), and a complex one. The state Opposition has been critical of EPAS costs adding up – and increasing – and EPAS's introduction so far has certainly not been trouble free.

The AMA(SA) viewed the initial introduction of EPAS at the first three hospitals as a test environment,

and stressed to the Department of Health that issues raised should be addressed before further rollout of the new system. The Association also stressed that training and appropriate support resources for those using the system are vital, and spoke with members and others at all three hospitals to ascertain where there are areas of concern and how the implementation is progressing.

With the new RAH designed to be a paperless hospital, the imperative for EPAS to work is even stronger. The AMA(SA) view is that the Department needs to listen closely and act decisively on the feedback it receives from those on the front lines to ensure that concerns are addressed. We have also asked for any contingency plans in the event the system is not functional in time to cope with the new hospitals demands. The AMA(SA) is watching the EPAS situation closely and listening to members.

WorkCover reforms advance
In August the state government introduced into Parliament what it described as "the most significant reform of workers' compensation in more than 25 years". The Return to Work Bill was proposed to replace the old WorkCover scheme with an entirely new Act which the government claimed would save registered businesses in SA more than $180 million per year.

The Return to Work Bill and accompanying South Australian Employment Tribunal Bill (which would establish a tribunal to review certain decisions arising from the new scheme) were passed through the House of Assembly in September.

The AMA(SA) supported early assessment of claims to allow timely treatment and therefore support return to work. We said that any restrictions on payments must not be such that they go against the objective of early assessment and treatment by creating fiscal barriers. The AMA(SA) and RANZCP also both supported a different psychiatric model of assessment to that being proposed (GEPIC rather than PIRS). The AMA(SA) also supported many of the issues raised by the Law Society regarding access to the scheme, and encouraged the government to amend the Bill to reduce opportunity for legal argument which would only cause uncertainty for workers and doctors trying to operate under the scheme.

The AMA(SA) maintained that there must be significant medical involvement in the development of any treatment protocols and guidelines that effect patient outcomes.

Boards struck off
The government announced it would be abolishing 105 boards and committees, with others to be merged or otherwise reformed, 58 being subject to further investigation, 117 to be reclassified and 72 under consideration for retention. Government boards and committees were advised by the Premier that unless they could make a case that they were absolutely required, they would go.

The AMA(SA) flagged its close interest in any changes for the SA Health Practitioners Tribunal, Health Performance Council, Veterans Health Advisory Council, Health Advisory Councils, SAMET and a range of other committees and entities of relevance to health and medicine.

Commissioner(s) for Children and the Royal Commission into the Safety of Children at Risk
The AMA(SA) responded with submissions to two bills to introduce a Commissioner for Children and Young People for SA.

Opposition Health Spokesman Stephen Wade's bill passed the Legislative Council, including noteworthy amendments intended to enhance independence, which had been a key concern and interest of the AMA(SA) in its advocacy in response to both bills. It has since been introduced in the House of Assembly.

Meanwhile, the government's Child Development and Wellbeing Bill passed the House of Assembly with signs of amendments to be considered for its next step in the Legislative Council. The AMA(SA)'s submissions can be found on our website.

While there are arguments about what is the best model, and certainly room for improvement, finally gaining this important role should still be an important step forward.

Royal Commission into the Safety of Children at Risk
The AMA(SA) provided feedback on the government's draft terms of reference for the Royal Commission into the Safety of Children at Risk. We proposed that the inquiry's remit include the important aspect of how to support less children to require out of home care and how to protect more children through earlier and enhanced responses. This suggestion was not taken up explicitly in the final terms of reference.

Advanced Care Directives
1 July 2014 marked the implementation date of the Advance Care Directives Act 2013 and the 7 Step Pathway. Advanced Care Directives legislation presents an important step forward to protect patient wishes and help to prevent futile care that is unwanted and unneeded, with significant costs and distress to individuals, families and the system. The AMA(SA) called for comprehensive, practical focused support to help implement this important initiative. The new legislation and the 7 Step Pathway represent the critical first two elements in the development of a coherent statewide strategy to change the landscape in end-of-life decision making and care for the better. One of the important challenges of our health system is ensuring that care provided remains consistent with people's wishes, even when they are not able to express them themselves.

Highlights | 2014

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 Karthik Venkataraman (Adelaide) and Sudheendra (Sunny) Krishna (Flinders). Both have made significant contributions among students and in their schools, in addition to their academic achievements.

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 2014, the Medical Educator award was conferred on Dr Hugh Kildea, while the award for Outstanding Contribution to Medicine went to Dr Ruth Marshall and the President's Medical Leader Award to Dr Andrew Lavender.

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.

Fifteen long-term AMA(SA) members were made life members of the Association at the start of 2014. Our sincere thanks go to Dr Douglas Allen, Dr Michael Bollen, Dr John Burry, Dr Rodney Carter, Dr Donald Clarkson, Dr David Davidson, Dr Robert Edwards, Dr Ernest Flock, Dr David Gill, Dr Richard (Clive) Matthews, Dr William McCoy, Dr Rex Pearlman, Dr John Turnbull, Dr Orietta Wicks and Dr Robert Wight for their support of the Association, as well as their service to patients and support of colleagues.

AMA(SA) preferred providers

The AMA (SA) thanks our preferred providers for their contribution in 2014: Hood Sweeney, Commonwealth Bank, Norman Waterhouse Lawyers and GP Payroll, with benefits also offered through the BMW Corporate Program and Thesinger and Turner Travel Associates.

Training and Education

The launch of AMA(SA) Training took place in 2014, offering creative solutions to general practice, allied health and the primary health sector through the provision of quality nationally recognised VET training. Our goal is to develop and support a vision of excellence and quality of training within the health sector.

In addition, sapmea 'came home' in 2014 by moving back into AMA House on Ward St, North Adelaide. sapmea and AMA(SA) have formed a strategic alliance to deliver both accredited, non-accredited and VET education for health professionals and practice staff. This year sapmea has provided workshops on Musculoskeletal Injuries, CPR, Definitive Surgical Trauma Care and Women's Health, as well as delivering the RDASA Inaugural Education Forum. AMA(SA) Training delivers eight VET health-related qualifications and has on-line learning capacity to provide greater access opportunities for all students wherever they are.

AMA(SA)'s Key Priorities for Health

This document was released in the lead-up to the State Election. It provided an overview of some key elements, priorities and concerns that the Association sought to highlight as the government and those who lead it, as well as other leaders and stakeholders, considered what was needed in our state for 2014 and beyond it. It led to a number of opinion pieces around key themes and issues in the Advertiser.

Events and Charity Support

The AMA(SA)'s annual black tie charity Gala Dinner at the Hilton International Adelaide on 17 May was again a great success, providing a chance to catch up with colleagues.

The 2014 dinner supported HeartKids SA, which provides support to families of children with heart disease and works to raise money for research on reducing the incidence of childhood heart disease.

The AMA(SA) donated $10,000 to HeartKids, with a further $2890 raised on the night.

Another highlight of the year for members and their guests was the Melbourne Cup Lunch, held on Tuesday 4 November at the Adelaide Oval Cathedral Room, Eastern Stand. The luncheon was held in conjunction with the Law Society of South Australia and Chartered Accountants Australia and New Zealand. The event was a fundraiser for Cancer Council SA, The Smith Family and Hutt St Centre – $3,992.00 was raised for each of the charities.

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 on 10 November.

Last but not least, the annual Christmas party held jointly on 14 November with the RACGP SA&NT again proved a great family-friendly event, enjoyed by members of both organisations, and the annual President's Breakfast on 2 December provided an important opportunity to say thank you to all those who help and work with the AMA(SA) throughout the year.

AMA(SA) Council | Changes

Changes to the AMA(SA) Council during the year 2014

Retiring Councillors

- Dr Susan Baillie retired from the position of Ordinary Member, a position she has held since June 2012.
- Dr Peter Ford retired from the position of Ordinary Member, a position he has held since August 2013.
- Dr Oluwadare Kuku retired from the position of Regional Representative Northern, a position he has held since June 2012.
- Dr Roger Sexton retired from the position of Ordinary Member, a position he has held since July 2012.
- Dr Andrew Shepherd retired from the position of Doctors in Training Representative, a position he has held since June 2012.
- Dr Stephan Van Eeden retired from the position of Ordinary Member, a position he has held since August 2012.
- Dr Rahul Solanki retired from the position of Ordinary Member, a position he has held since June 2012.

Election of Craft Group and Other Representatives

- **Regional Representative – Northern**
  Dr Nigel Stewart was re-elected to this position by AMA(SA) Council.
- **Regional Representative – Northern**
  Dr John Williams was re-elected to this position by AMA(SA) Council.
- **Regional Representative – Southern**
  Dr Trevor Hodson was elected to this position by AMA(SA) Council.
- **Regional Representative – Southern**
  Dr Peter Tait was elected to this position by AMA(SA) Council.
- **Doctors in Training Representative**
  Dr Thomas Crowhurst was elected to this position by AMA(SA) Council.

Election of Office Bearers

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

Election of Ordinary Members

- Dr Tarun Bastiampiallai was elected to this position by AMA(SA) Council.
- Dr Matthew McConnell was elected to this position by AMA(SA) Council.
- Dr Christopher Moy was re-elected to this position by AMA(SA) Council.
- Dr Clair Pridmore was elected to this position by AMA(SA) Council.
- Dr Emma Rischbieth was elected to this position by AMA(SA) Council.
- Dr David Sainsbury was elected to this position by AMA(SA) Council.
- Dr David Scrimgeour was elected to this position by AMA(SA) Council.
- Prof Paul Worley was elected to this position by AMA(SA) Council.

Federal Councillors

- Dr Patricia Montanaro was appointed to the office of State Nominee.
- Dr Christopher Moy was appointed to the office of Area Nominee SA/NT.
- A/Prof Susan Neuhaus CSC was elected to the office of Craft Group Nominee.

AMA(SA) Standing Committees

January - December 2014

Doctors in Training Committee

Chair: Dr Thomas Crowhurst
Immediate Past Chair: Dr Andrew Shepherd
Deputy Chair: Dr Sam Kirchner
Secretariat: Mr Joe Hooper, Ms Tracey DiBartolo
Members: Drs Mathew Amprayil, David Barlow, Cassandra Chaptini, Heng T Chong, Brian Chui, Tony Farfus, Ben Finlay, Sam Fitzgerald, Edward Gibson, Sean Jolly, Lachlan McMichael, Kyra Sierakowski, Patrick Tam, Katherine Watson, Ms Victoria Cox
Student Medical School Representatives: Mr Nick Stock, Ms Alyssa Parsons
Reference Group Members: Drs Manuel Aranibar, Adam Badenoch, George Balalis, David Barlow, Angela Chang, Cassandra Chaptini, Morven Crane, Phil Deacon, Nuwan Dharmawardan, Alison Edgecomb, Lachlan Farmer, Rick Fielke, Ben Finlay, Sam Fitzgerald, John Floridis, Mark Hassall, Sanj Mudaliar, Adam Nelson, Minh Nguyen, Ian Olszewski, Tom Paxton, Kristen Pierides, Emma Rischbieth, Ross Roberts-Thomson, Daina Rudaks, Shane Selvanderan, Rahul Solanki, Patrick Tam, Samuel Whitehouse

Council of General Practice

Chair: Dr Chris Clohesy
Secretariat: Mr Joe Hooper, Ms Tracey DiBartolo
Members: Drs Sue Baillie, Mike Beckoff, Peter Ford, Richard Heah, Andrew Kellie, Jane Kitchen, Oluwadare Kuku, Patricia Montanaro, Chris Moy, Penny Need, Annette Newson, Cathy Sanders, 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 William Heddle, Robert Menz, Patricia Montanaro, Christopher Moy, Michael Rice and Melissa Sandercock

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 and Ms Claudia Baccanello
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, A/Prof William Tam and Mr John Mclaren.

Federal AMA Committees

AMA(SA) Members

January – December 2014

Federal Council
Dr Christopher Moy
Dr Patricia Montanaro
A/Prof Susan Neuhaus CSC (Surgeons)
Dr Peter Sharley - to May 2014

Audit and Risk Committee
Dr Peter Sharley - to May 2014

Ethics and Medico Legal Committee
Dr Christopher Moy

Finance Committee
Dr Peter Sharley – to May 2014

Economics and Workforce Committee
Dr Patricia Montanaro

Health Financing and Economics
A/Prof Susan Neuhaus CSC

AMA Rural Medical Committee
Dr Nigel Stewart

AMA Council of Salaried Doctors
Dr Andrew Russell

Taskforce on Indigenous Health
Dr David Scrimgeour

AMA Council of Doctors-in-Training
Dr Andrew Shepherd - to May 2014
Dr Thomas Crowhurst - from June 2014
Dr Sam Kirchner (Alt)

AMA Council of General Practice
Dr Christopher Clohesy
Dr Patricia Montanaro
Dr Annette Newson

AMA National Disability/ Injury Insurance Scheme Taskforce
Dr Patricia Montanaro
Dr James Rice

AMA Defence Health Working Group
A/Prof Susan Neuhaus CSC

Medical Practice
Dr Christopher Moy
Dr Patricia Montanaro

End of Life Working Group
Dr Christopher Moy

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 Chair of the AMA(SA) Executive Board

Dr Trevor Mudge

The Executive Board has now completed its second full year of operations.

It has now established its place in the workings of the AMA(SA) and is providing advice to the Council on matters fiduciary, thereby freeing Council to spend its time on policy development. Council retains its governance responsibility for the affairs of the AMA(SA). This has given effect to Council's vision in establishing the Executive Board nearly three years ago. I believe that your Board is functioning effectively and collectively. Amongst our principal strategic objectives is horizon scanning to position the AMA(SA) to take advantage of likely future trends in the future of medical practice to strengthen our position as the go-to organisation for the profession.

Financial report

The 2014 financial report for members' information is presented on pages 17-22. We remain in a stable financial position and continue to record satisfactory results in maintaining our expenditure within the bounds of our income. Significant but careful investments are being made in the Registered Training Organisation and in the options for Newland House.

sapmea

Our relationship with sapmea continues to develop and progress is being made on joint venture projects between our organisations. AMA(SA) Training is the first of these to benefit from the bridge between our two organisations but we expect there will be others in the near future.

Building

As members will know, Newland House does not meet a number of occupational health and safety requirements. Options for modernisation, redevelopment or sale are being carefully canvassed in order to provide appropriate advice to Council on options for the future accommodation for the AMA(SA) and its activities. Advisedly this is a somewhat protracted process and is still in progress. The importance of our future needs however is clearly vital.

Registered Training Organisation

AMA(SA) Training Services has achieved national accreditation. Progress has been slow in the current climate as there is an effective funding freeze at both state and federal levels of government. As reflected in the press there has been criticism of the practices of some organisations in this sector and further regulation will have a shakeout effect. As we have always complied with the highest possible standards in this area we are likely to eventually benefit from these changes and your Board remains confident of the long-term future of the RTO.

Membership

In a membership organisation, membership is clearly of primary importance. We have a focus on recruitment of doctors in training, and on retention of existing members. The Board has appointed the chair of the Doctors in Training Committee to the Board ex officio and we continue to work closely with this group to be as responsive as possible to their needs. It is comforting to observe that since November 2012, membership has grown by 11%. We remain convinced however that in the future the AMA(SA) will need to develop alternative sources of income to reduce our reliance on subscriptions and we will continue to do so in the longer term.

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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 2014, 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 2014 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

JIM GOUSKOS
DIRECTOR
ADELAIDE
Dated, this 24th day of March 2015

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 DECEMBER 2014	Note	2014 $	2013 $
Revenue	2	1,460,811	1,374,869
		1,460,811	1,374,869
Employee benefits expense		(669,696)	(628,498)
Depreciation and amortisation expenses		(24,529)	(21,391)
Rates and taxes		(103,537)	(98,836)
Presidential allowance		(53,220)	(53,220)
Printing and stationery		(7,342)	(8,100)
Insurance		(10,416)	(10,040)
Postage		(4,176)	(5,802)
Repairs and maintenance		(18,981)	(10,497)
Strata Levy		(67,486)	(62,543)
Telephone		(13,130)	(16,263)
Other expenses from ordinary activities	3	(292,312)	(260,684)
Legal fees		(7,353)	(3,813)
Donation		(10,675)	(10,300)
Gala Dinner expense		(65,941)	(80,617)
RTO consulting expense		(99,015)	(30,882)
Prizes/Awards		(400)	(400)
Profit before income tax		12,602	72,983
Income tax expense / benefit	4	(63,567)	(13,420)
Profit for the year		(50,965)	59,563
Other comprehensive income			
Net gain on revaluation of building		210,000	-
Other comprehensive income for the year, net of tax		210,000	-
Total comprehensive income attributable to members of the entity		159,035	59,563

STATEMENT OF FINANCIAL POSITION AS AT 31 DECEMBER 2014	Note	2014 $	2013 $
ASSETS			
Current assets			
Cash and cash equivalents	6	720,700	753,895
Trade and other receivables	7	49,994	48,371
Other current assets	8	48,481	24,978
Total Current Assets		819,175	827,244
Non-current assets			
Property, plant and equipment	9	4,278,973	4,085,784
Deferred tax assets	14	249,641	268,722
Total Non-Current Assets		4,528,614	4,354,506
TOTAL ASSETS		5,347,789	5,181,750
LIABILITIES			
Current liabilities			
Trade and other payables	10	717,553	714,567
Finance Lease liabilities	12	2,021	8,085
Other current liabilities	11	-	12,800
Total Current Liabilities		719,574	735,452
Non-current liabilities			
Long-term employee benefits	13	-	21,604
Deferred tax liabilities	14	361,736	317,250
Total Non-Current Liabilities		361,736	338,854
TOTAL LIABILITIES		1,081,310	1,074,306
NET ASSETS		4,266,479	4,107,444
EQUITY			
Reserves	16	1,200,305	990,705
Retained earnings		3,066,174	3,116,739
TOTAL EQUITY		4,266,479	4,107,444

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 DECEMBER 2014	Retained Earnings $	Reserves $	Total $
Balance at 1 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
Balance at 1 January 2014	3,116,739	990,705	4,107,444
Total comprehensive income for the year			
Profit attributable to members of the entity	(50,965)	-	(50,965)
Other comprehensive income for the year			
Fund movements/ transfers	400	(400)	-
Net gain on revaluation of building	-	210,000	210,000
Total other comprehensive income for the year	400	209,600	210,000
Total comprehensive income for the year	(50,565)	209,600	159,035
Balance at 31 December 2014	3,066,174	1,200,305	4,266,479

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 DECEMBER 2014	Note	2014 $	2013 $
Cash flows from operating activities:			
Receipts from members, tenants and others		1,447,755	1,333,750
Payment to suppliers and employees		(1,538,674)	(1,197,042)
Interest received		11,433	14,368
Finance costs		(3,494)	(7,233)
Income tax paid		63,567	13,420
Net cash/ (used in) provided by operating activities		(19,413)	157,263
Cash flow from investing activities:			
Purchase of plant and equipment		(7,718)	(25,433)
Net cash/ (used in) investing activities		(7,718)	(25,433)
Cash flow from financing activities:			
Proceeds from borrowings		(6,064)	8,085
Net cash provided by financing activities		(6,064)	8,085
Net cash increase in cash held		(33,195)	139,915
Cash and cash equivalents at the beginning of the financial year		753,895	613,980
Cash and cash equivalents at the end of the financial year	6	720,700	753,895

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 DECEMBER 2014

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 dollor.

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

	2014 $	2013 $
Operating Revenue		
- interest	11,433	14,368
- rent	314,793	302,559
- advertising (medical review)	155,794	124,827
- member subscriptions	722,046	663,494
- sundry revenue	162,695	166,494
- gala dinner income	94,050	103,127
Total revenue	1,460,811	1,374,869

NOTE 3 | PROFIT FOR THE YEAR

Expenses		
- finance costs	3,494	7,233
Other expenses		
- bad debts	200	50

NOTE 4 | INCOME TAX EXPENSE

a. The components of tax expense comprise:		
Current tax	63,567	13,420
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% (2013: 30%)	3,781	22,015
Less:		
Tax effect of:		
– other non-temporary differences	15,300	(7,995)
– Revaluation of buildings	44,486	(600)
Income tax attributable to the association	63,567	13,420
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	317,720	284,146

Other KMP transactions
For details of other transactions with KMP, refer to Note 17: Related Party Transactions.

NOTE 6 | CASH AND CASH EQUIVALENTS

Cash on hand	300	300
Cash at bank	720,400	753,595
	720,700	753,895

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	720,700	753,895

NOTE 7 | TRADE AND OTHER RECEIVABLES

Trade receivables	51,994	50,371
Less: Provision for doubtful debts	(2,000)	(2,000)
	49,994	48,371

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

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

	Opening balance $ 1 Jan 2014	Charge for the year $	Amounts written off $	Closing balance $ 31 Dec 2014
Current trade receivables	2,000	-	-	2,000

	2014 $	2013 $
7b. Financial assets classified as loans and receivables		
Trade and other receivables		
- Total current	49,994	48,371
- Total non-current	-	-
	49,994	48,371
Financial assets	49,994	48,371

NOTE 8 | OTHER CURRENT ASSETS

Prepayments	14,785	24,978
Other	33,696	-
	48,481	24,978

NOTE 9 | PROPERTY, PLANT AND EQUIPMENT

Land and Buildings		
Newland House -		
At Independent Valuation 2014	1,600,000	1,480,000
AMA House -		
At Independent Valuation 2014	2,520,000	2,430,000
Total Land and Buildings	4,120,000	3,910,000
Furniture and Equipment		
Branch - at cost	224,543	217,423
less: Accumulated Depreciation	(130,592)	(107,725)
	93,951	109,698
AMA - at cost	7,342	7,342
less: Accumulated Depreciation	(6,049)	(5,125)
	1,293	2,217
Antiques and Paintings - At Valuation	64,539	64,539
less: Accumulated Depreciation	(810)	(670)
	63,729	63,869
Total Furniture and Equipment	158,973	175,784
Total property, plant and equipment	4,278,973	4,085,784

(a) Movements in Carrying Amounts

	Buildings	Furniture and Equipment	Total
Balance at 1 January 2014	3,910,000	175,784	4,085,784
Additions	-	7,718	7,718
Disposals	-	(598)	(598)
Depreciation expense	-	(23,931)	(23,931)
Revaluation increments	210,000	-	210,000
Carrying amount at 31 December 2014	4,120,000	158,973	4,278,973

NOTE | 10 TRADE AND OTHER PAYABLES

CURRENT			
Unsecured liabilities			
Trade payables		36,254	25,488
Employee benefits (refer note 13a)		-	19,244
Subscription in advance		635,135	612,700
Sundry creditors and accruals		46,164	57,135
		717,553	714,567
a. Financial liabilities at amortised cost classified as trade and other payables			
Trade and other payables			
- Total current		717,553	714,567
- Total non-current		-	-
		717,553	714,567
Less subscriptions in advance		(635,135)	(612,700)
Less employee benefits		-	(19,244)
Financial liabilities as trade and other payables	18	82,418	82,623

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

NOTE 12 | LEASE LIABILITIES

	2014 $	2013 $
CURRENT		
HP Lease liability	2,021	8,085
	2,021	8,085

NOTE 13 | LONG TERM EMPLOYEE BENEFITS

Long-term employee benefits (refer note 13a)	-	21,604

a. On 1 July 2014, the association ceased employment of all its employees, except for the CEO who ceased on 1 October 2014. The association subsequently engaged SAPMEA on 1 July 2014, to provide labour hire services to AMA SA. Employee entitled benefits were paid out to SAPMEA upon cessation of employment, and no employee entitled benefits were outstanding at balance date.

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 2013	317,250	-	-	317,250
Fair value gain	317,250	44,486	-	361,736
Balance at 31 December 2014	317,250	44,486	-	361,736
Deferred tax assets				
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
Provisions	13,870	-	(13,270)	600
Deferred expenditure	1,952	-	1,624	3,576
Carried forward tax losses	252,900	-	(7,435)	245,465
Balance at 31 December 2014	268,722	-	(19,081)	249,641

NOTE 15 | CAPITAL AND LEASING COMMITMENTS

a. Finance lease Commitments		
Payable - minimum lease payments		
- no later than 12 months	2,223	6,672
- between 12 months and five years	-	2,223
- later than five years	-	-
	2,223	8,895
Minimum lease payments	2,223	8,895
Less future finance charges	(202)	(810)
Present value of minimum lease payments	2,021	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	287,828	316,977
between 1 and 5 years	625,431	896,907
	913,259	1,213,884

NOTE 16 | RESERVES

Asset Revaluation Reserve (a)	1,160,950	950,950
De Crespigny Memorial Fund (b)	3,268	3,468
Listerian Oration Fund (c)	3,662	3,662
Frank S Hone Memorial Fund (d)	12,716	12,916
Southern Suburbs Medical Association (e)	19,709	19,709
	1,200,305	990,705

(a) Asset Revaluation Reserve

Movements during the financial year:		
Opening balance	950,950	950,950
Revaluation of building	210,000	-
Closing Balance	1,160,950	950,950

The asset revaluation reserve records revaluations of non-current assets

	2014 $	2013 $
(b) De Crespigny Memorial Fund		
Movements during the financial year:		
Opening balance	3,468	3,668
University of Adelaide - Awards 2013	(200)	(200)
Closing Balance	3,268	3,468

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
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	12,916	13,116
University of Adelaide - Awards 2013	(200)	(200)
Closing Balance	12,716	12,916

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
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	720,700	753,895
Loans and receivables	49,994	48,371
Total financial assets	770,694	802,266
Financial liabilities		
Financial liabilities at amortised cost:		
– trade and other payables	82,418	82,623
– borrowings (lease liabilities)	2,021	8,085
Total financial liabilities	84,439	90,708

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 2014:-

(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, Dr P Montanaro, of the Australian Medical Association (SA) Inc. received an allowance of $53,220 in carrying out duties on behalf of the Association.

- The Australian Medical Association (SA) Inc. engaged McLaren Consulting Pty Ltd on normal commercial terms and conditions during the year for $4,500 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 2 to 18:

(a) Presents a true and fair view of the financial position of Australian Medical Association (SA) Inc. as at 31 December 2014 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 19 March 2015

AMA SOUTH AUSTRALIA

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AMA
SOUTH AUSTRALIA