

# rdasa

Rural Doctors' Association  
of South Australia Inc.



## **ANNUAL REPORT 2010 - 2011**

Annual General Meeting  
Friday 11<sup>th</sup> November 2010

Glenelg Pier Hotel  
Glenelg

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# President's Report

*November 2011*

I have pleasure in presenting the 2011 President's report. It has been an interesting twelve months as federal government health reform has impacted on rural doctors at the time of our Country Health negotiations. These negotiations have tried to incorporate and acknowledge some future roles of rural doctors in their country hospital work. At the time of presenting this report we have not yet concluded negotiations, but I can report likely outcomes.

Peter Rischbieth, Graham Morris and David Senior have been diligent in representing and implementing member's views, primarily driven by our 2011 workforce survey. Thanks to all who participated in the survey, whether RDASA members or not.

You asked for payments to allow time off when up all night and these seem likely to be approved as a safe work-hours issue. We have negotiated that CHSA will pay for attendance to triage levels 1, 2 and 3 at Country Health hospitals and we seem likely to get higher fees for attending CHSA meetings.

Whilst we have remained firm on pay equality as our goal, it seems that with our increased role in teaching likely; hospitals that deliver more than 250/year will have an alternate sessional model of remuneration. The same seems likely for those hospitals with a higher numbers of anaesthetics.

Signing the contract, when all parties agree, is important to those who teach. Legal advice reveals that registrars can only be supervised by doctors who have signed a contract with CHSA to work in Country Health hospitals.

The future of rural practice is something dear to our hearts. RDAA is advocating for a National Advanced Rural Training pathway, scrapping of the ASGC rural classification, and advocating for a Medicare schedule fee for those in rural areas. RDASA has been involved in the SA rural generalist pathway and fully supports a rural generalist pathway with quarantined training places. We know that rural doctors have the skills to teach post graduate procedural rural medicine. Indeed, Martin Altmann and Lucy Walters have pioneered DRANZOG training in rural areas.

Leaving our industrial negotiations, we were asked to become involved with the Keith hospital when the Government removed its support for three rural community hospitals; Keith, Ardrossan and Moonta. RDASA worked to support the provision of appropriate services to our colleagues in those towns and I especially thank Peter Rischbieth for his negotiations with the Keith board. At the time of writing the hospital boards are adapting to new roles. Whilst the change in role of any rural hospital is disappointing, I must add that CHSA has been at pains to assure us there are no plans for closing or changing roles at any CHSA rural hospitals.

On an organisational level, we saw our Executive Officer of 11 years, Cass McNeil leave us for a full time job. Her work was of the highest order, and we wish her well in her new endeavours. Her replacement is Suzanne Mann, who has come with new energy and ideas. The new logo and ongoing redevelopment of our website is her touch. We took the chance to update our Executive Officer contract and Suzanne will be actively recruiting new members, so please fill out a membership before she gets to you. Suzanne will also be actively pursuing sponsorship to support the endeavours of RDASA – a first for the organisation.

Our regular meetings with Belinda Moyes of CHSA have allowed us to advocate on your behalf and effectively represent the issues faced by rural doctors and general practice. We have pushed for better IT access at CHSA sites albeit with limited success. However EPAS, the new

SA Health IT system, will be rolled out in all hospitals over the next 3 years and we will assess its usefulness when we see it. We have also advocated for coordinated point of care testing again with limited success as the two players, State Pathology and Phil Tidemann, have different systems. We have continued to stress the need for a single point of contact when transferring urgent but not critical patients to metropolitan hospitals. We advocated for better access to the Lyell McEwin hospital for emergencies and I have been advised a helipad will be opened next year - a win. We lobbied for a better method of replacement of ageing infrastructure such as theatre and obstetric beds in an age of increasingly heavy patients. In this area, I would like to thank Richard McKinnon for his work in getting a state bariatric protocol re-engineered to take into account rural needs.

Our members are not only generalists, but also include specialist members. We have had lengthy discussions with CHSA about succession planning on behalf of our specialist members and CHSA are very aware of this need and our position regarding succession.

Health reform in the shape of Medicare Locals will need constant monitoring to ensure they support better service delivery to rural areas. The Health Information Unit of the University of Adelaide led by Prof John Glover tells us the rural health outcomes are getting wider compared to our metropolitan cousins. Gaps in areas such as cancer, cardiovascular mortality and premature mortality have increased in the past decade. The recent RDAA conference highlighted the need for clinicians to drive meaningful health care improvements. As rural GPs, we are on the ground and understand our local community needs. This conference has seen some important research along those lines, and I urge you all to become involved.

RDASA feels that we have not supported our international medical graduates and female doctors as well as we might have. We wish to establish an IMG working group as well as a female doctor working group to allow the RDASA management committee to be aware of the particular issues these members face. I ask that anyone who could spare one to two hours on a teleconference two to three times a year please contact Suzanne Mann.

RDASA operates in partnerships to assist its members. I thank all members who have so willingly contributed their views, whether committee members or not. As volunteers, we try to respond to your queries and get answers from relevant authorities. We liaise with CHSA, State Health, the AMA, GPET, Divisions of General Practice, ACRRM, RDWA, and sapmea on your behalf, and I am grateful to RDWA CEO Lyn Poole and her team for staging another fantastic annual conference and the opportunity to conduct our AGM.

The next few years are critical for ensuring that rural generalists prosper so that rural communities have their health outcomes improved. RDASA will support any reforms along these lines. We are there for you as your state based, member organisation to assist you to deliver the best health care. Your membership allows your views to be represented, and I urge any of you here today who aren't members to join.

In closing, thanks to Cass and Suzanne for their work as Executive Officers, to the Executive Committee for its valued input and to all who have given me assistance this year.

**Tim Wood**  
**Rural doctor - Kadina**  
**President – RDASA**

## **Vice President Report - Industrial**

***November 2011***

The RDASA industrial negotiators, Graham Morris, David Senior and Peter Rischbieth have spent many hours this year meeting with Country Health SA, in conjunction with the AMA, to consider the proposed industrial contract and conditions of service for GPs providing services in rural hospitals in South Australia from December 2011.

Some of the key issues in the negotiations include; recognition of safe working hours for rural GPs providing services in rural hospitals, providing primary health care services the day after a night on call, remuneration for clinical audits, administrative meetings and call outs to hospitals during consulting times as well as the remuneration package for doctors providing on call services over a 24 hour period and weekends.

It is anticipated there will imminently be a new agreement available for members and for rural doctors to consider. There is ongoing work to be done in as far as the provision of IT services for rural hospitals, the recognition of the teaching commitment that rural GPs play in rural hospitals and the lack of point of care testing in many rural hospitals (the implementation of which had been proposed by CHSA in the Country Health Plan over four years ago).

RDASA recognises the significant contribution that rural GPs play in their community especially those who provide emergency after hours and procedural services, mental health services and secondary care in hospitals. Many practices are struggling to juggle the commitments of primary health care provision and teaching commitments as well as their hospital service roles and RDASA continues to make governments, educators and workforce bodies aware of this situation.

It is very pleasing that CHSA and the Rural Doctors Workforce Agency recognise the need to have a structured rural training pathway for future rural GPs. RDASA itself has been involved in a number of the discussions, with many of our members being on the steering committee and represented at the workshops. These provided a great forum for considering and planning for some of the workforce issues for the future. We look forward to this pathway being implemented in the near future as part of a national rural generalist training initiative which RDAA is promoting with the Commonwealth government and Health Workforce Australia.

RDASA thanks the staff of the RDWA for its fine work and support during the year under the stewardship of CEO Lyn Poole and Chair Richard McKinnon. RDASA would also like to acknowledge our nominees to the RDWA board and thank them for their commitment.

In our meetings with the State Health Minister, John Hill, RDASA has continued to advocate for support for international medical graduates who have poor access to Medicare services and education for their families and themselves. At the national level, RDAA has presented to the Senate inquiry into the international medical graduate workforce and called for the abolition of the 10 year moratorium on international medical graduate placements.

We have made Minister Hill very aware of the importance of having an easier journey for patients transferred to metropolitan hospitals and the often confusing area of who to contact when seeking assistance in the transfer process. CHSA has also been briefed on this matter and we look forward to more information being available as to how we can simplify and streamline this often complicated pathway to access metro admissions.

RDASA has also held discussions with Minister Hill on the Medicare Local implementation and in particular made clear our concerns that the provision of after-hours services may be impacted due to these changes.

We are very aware of the negative effect that the new rural classification scheme ASGC-RA has on many smaller towns, potentially jeopardising their ability to attract doctors. RDASA is calling on the federal government to scrap the current scheme and to ensure that there is better data available to understand the rural doctor workforce and its capability to provide services into the future. RDASA has been active in discussions with Health Workforce Australia to study this further especially after our survey early 2011 showed that many rural patients were waiting over 4-6 weeks to access their normal family doctor.

Our continued advocacy and representation of rural doctors is not possible without our membership and their willingness to provide feedback and to nominate for task forces and committees. I sincerely thank you for your current support and urge you to continue to support the RDASA into the future so that we can advocate for you and deliver improvements and increases in health services and the workforce for our rural communities.

I would also like to thank the Executive and the regional representatives for their time and energy on the RDASA committee. Suzanne Mann has joined our team as Executive Officer and is providing dynamic energy to the organisation. I would like to personally thank Cassandra McNeil for her great efforts over the last 11 years as executive officer. I thank her especially for the time and commitment she displayed during her tenure, especially in relation to the response to the SA Government failed Rural Health Plan in 2008.

Tim Wood has provided great leadership for the organisation in the last twelve months and RDASA looks forward to the future with a new industrial contract in place for rural GPs, greater IT support under the EPAS system and a new rural pathway training scheme for doctors wanting to come and join us in rural South Australia whilst following the very rewarding career pathway as a rural GP.

**Peter Rischbieth**  
**Rural doctor – Murray Bridge**  
**Vice President (Industrial) RDASA**

# Vice President's Report

*November 2011*

Colleagues,

It is with pleasure that I present my Vice Presidential report for 2011 to the RDASA Annual General Meeting.

The last year has been eventful, with our members adjusting to considerable medical environmental change. This is likely to continue – it could be argued that policy makers can, by creating massive change in many areas, force rural doctors to retreat to what we do best which is caring for patients and communities. Often we let the rest take its course. In other words, they can worry us through both policy and the dynamics of change.

It is likely that we will be practising in a more austere fiscal environment during the next few years. Most of our members have no experience of medical practice without Medicare. Further rebate reductions across a number of areas will result in patient contributions to their health care increasing. Consideration could be given to tracking both mortality and morbidity arising from this. Especially as we know that in times of austerity, coupled with problems in accessing health care, patients allow their health issues to remain unmanaged with poorer outcomes as a result.

In my report to the 2008 AGM, I mentioned increased training of nurses to supply medical services. The result is now with us as nurse practitioners are accepted and encouraged by State Health departments. Our position as managers of complex care requires firm consideration and scope definition. I described the need for us to determine and to state our work value, and I fear that unless we address this now, with an emphasis on the differences between rural medicine and the rest, we will be left in a weaker position. It is interesting to note that this situation has confronted RDAA in the past. It responded by carrying out a rigorous academic appraisal of the differences, which were significant. Policy makers and funders require that degree of detail and persuasion, and I suspect that time is upon us again as funders also require that detail in times of austerity.

I regret to say that history shows a lack of support from most other medical quarters when the issue of rural doctor work difference and value arises. That is sad, true, and divisive. We should understand that we are likely to be alone in our endeavours but it is fortunate that by comparison with decades past, we now have a strong academic presence in rural medicine which allows us to collate and present the evidence. That was a strategic focus in the early days of RDAA and RDASA and I would predict that it will again become important, as we define our position in the system.

Coupled with this is the matter of rural doctor training. The SA Rural Training Pathway will be mentioned frequently during the AGM weekend and we must be ready to demonstrate the need for it based on the differences between our practice and that of non-rural doctors. We will encounter opposition from other GP organizations who fear our positioning of rural practice as a specialty but we should not forget that the Australian College of Rural & Remote Medicine has achieved full accreditation from the Australian Medical Council, and that its curriculum, training pathways and examination are based on rural and not urban practice. I would suggest that we should go forward, determining our strategic partners and collecting the evidence that defines whom we are and what we do. It is highly likely that we will need to again be prepared to justify our position.

**D.R. Rosenthal**  
**Rural doctor – Renmark**  
**Vice President RDASA**

# **Treasurer's Report**

***November 2011***

I present the audited financial statement for the 2010/11 financial year.

At the end of June 2011 there was \$41,691.04 in the bank, representing a profit of \$8,898.70. This is an improvement compared with last financial year, which resulted in a loss.

The main contributing factor to the improved figures was the reduction in legal fees this financial year. In the 2009/10 financial year, legal fees for contract negotiations with Country Health SA amounted to \$11,216. As the contracts were not due for renegotiation this year, there were no legal fees to pay, resulting in substantial savings. Legal fees are expected to increase again in the 2011/12 financial year as negotiations with Country Health SA recommence. The reduction in costs was also attributed to the lower telephone costs. This merely reflects a smaller number of teleconferences held in 2010/11 compared with 2009/10.

Secretarial costs increased by almost \$2,000.00 during the 2010/11 financial year. This reflects higher costs during April, when the changeover to our new Executive Officer occurred and both Suzanne Mann and Cassandra McNeil were being paid. The Executive Officer's hourly fee also increased. A new computer and software package was also purchased resulting in the substantially higher IT costs during 2010/11.

The income from membership subscriptions increased again, compared with the last financial year, reflecting an increase in subscription fees from \$400 to \$475 for full time rural doctor membership, rather than an increase in membership numbers which have remained relatively stable.

The RDAA moiety has remained constant at \$220.00 (including GST) for each full-time member.

While this year's financial outlook has been brighter than the past 2 years, we nevertheless need to continue to encourage new members to join, to keep our membership fees down and ensure the viability of this important association.

**Joanna Rutzen**  
**Rural doctor - Loxton**  
**Treasurer RDASA**

# Rural Doctors Association of SA Inc

## *Statement by Members of the Committee*

The Committee has determined that the Association is not a reporting entity and that this special purpose financial report should be prepared in accordance with the accounting policies outlined in Note 1 to the financial statements.

In the opinion of the Committee the financial report:

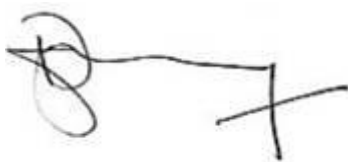
1. Presents a true and fair view of the financial position of Rural Doctors Association of SA Inc as at 30 June 2011 and its performance for the year ended on that date.
2. At the date of this statement, there are reasonable grounds to believe that Rural Doctors Association of SA Inc will be able to pay its debts as and when they fall due.

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



.....

**CHAIRPERSON**



.....

**EXECUTIVE OFFICER**

# **Rural Doctors Association of SA Inc**

## ***Compilation Report***

### *Scope*

On the basis of the information provided by the Committee of Rural Doctors Association of S.A. Inc we have compiled, in accordance with APS 9: Statement of Compilation of Financial Reports the special purpose financial report of Rural Doctors Association of S.A. Inc for the year ended 30 June 2011 comprising the attached Income and Expenditure Statement.

The specific purpose for which the special purpose financial report has been prepared is to provide financial information to the members. Accounting Standards and other mandatory professional reporting requirements have not been adopted in the preparation of the special purpose financial report.

The Committee is solely responsible for the information contained in the special purpose financial report and has determined that the accounting policies used are consistent with the financial reporting requirements of the Association's Constitution and are appropriate to meet the needs of the Committee for the purposes of complying with the Association's Constitution.

Our procedures use accounting expertise to collect, classify and summarise the financial information which the Committee provided into a financial report. Our procedures do not include verification or validation of procedures. No audit or review has been performed and accordingly no assurance is expressed.

To the extent permitted by law, we do not accept liability for any loss or damage which any person, other than the Association, may suffer arising from any negligence on our part. No person should rely on the special purpose financial report without having an audit or review conducted.

The special purpose financial report was prepared for the benefit of the Association and the purpose identified above. We do not accept responsibility to any other person for the contents of the special purpose financial report.

**WHK**

**Dated at Loxton this 8th Day of November 2011**

**Income & Expenditure Statement**  
*for the year Ended 30 June 2011*

**Income**

Interest	\$	726.14
Membership Subscriptions	\$	50,523.84
		50,523.84
<b>TOTAL INCOME</b>	<b>\$</b>	<b>51,249.98</b>

**Less Expenditure**

Audit & Accounting Fees	\$	420.00
Computer & Website	\$	3,172.28
Gifts & Donations	\$	118.25
Media	\$	144.77
Postage & Delivery	\$	233.04
Printing & Stationary	\$	204.16
RDAAL Levy	\$	23,086.26
Secretarial Services	\$	11,227.50
Telephone	\$	3,169.48
Training/Recruiting	\$	284.00
Travel	\$	291.56
		42,351.28
<b>TOTAL EXPENDITURE</b>	<b>\$</b>	<b>42,351.28</b>
<b>Excess of Income over Expenditure</b>	<b>\$</b>	<b>8,898.70</b>

**Balance Sheet as at 30 June 2011**

**Current Assets**

Bank SA Cheque Account	\$	41,691.04
GST Refundable	\$	2,276.00
		43,967.04

**Equity**

Opening Balance 1 July 2010	\$	35,068.34
Less excess of income over expenditure 2011	\$	8,898.70
		43,967.04

## Profit & Loss Previous Year Comparison

*July 2010 – June 2011 compared to July 2009 – June 2010*

	<u>Jul '10 - Jun 11</u>	<u>Jul '09 - Jun 10</u>	<u>\$ Change</u>	<u>% Change</u>
<b>Ordinary Income/Expense</b>				
<b>Income</b>				
<b>Interest</b>	726.14000	322.61000	403.53000	125.0830%
<b>Membership Subscriptions</b>	50886.57000	45273.1000	5613.47000	12.3990%
<b>Sales</b>	.91000	90.91000	-90.000	-98.9990%
<b>Total Income</b>	<u>51613.62000</u>	<u>45686.62000</u>	<u>5927.000</u>	<u>12.9730%</u>
<b>Expense</b>				
<b>Gifts and Donations</b>	118.25000	.000	118.25000	100.00%
<b>Media Expenses</b>	144.77000	.000	144.77000	100.00%
<b>Office Supplies</b>				
<b>IT</b>	2854.14000	27.13000	2827.01000	10420.2360%
<b>Website</b>	318.14000	.000	318.14000	100.00%
<b>Total Office Supplies</b>	<u>3172.28000</u>	<u>27.13000</u>	<u>3145.15000</u>	<u>11592.8860%</u>
<b>Postage and Delivery</b>	233.04000	95.27000	137.77000	144.6100%
<b>Printing and Reproduction</b>	204.16000	690.54000	-486.38000	-70.4350%
<b>Professional Fees</b>				
<b>Accounting</b>	420.000	410.000	10.000	2.4390%
<b>Legal Fees</b>	.000	11216.000	-11216.000	-100.00%
<b>Total Professional Fees</b>	<u>420.000</u>	<u>11626.000</u>	<u>-11206.000</u>	<u>-96.3870%</u>
<b>RDAA levy</b>	23086.26000	23800.000	-713.74000	-2.9990%
<b>Recruiting</b>	84.000	.000	84.000	100.00%
<b>Reimbursement</b>	363.64000	.000	363.64000	100.00%
<b>Secretarial Services</b>	11227.5000	9270.7000	1956.8000	21.1070%
<b>Telephone</b>	3169.46000	5944.03000	-2774.57000	-46.6780%
<b>Training</b>	200.000	.000	200.000	100.00%
<b>Travel &amp; Ent</b>				
<b>Travel</b>	291.56000	.000	291.56000	100.00%
<b>Total Travel &amp; Ent</b>	<u>291.56000</u>	<u>.000</u>	<u>291.56000</u>	<u>100.00%</u>
<b>Total Expense</b>	<u>42714.92000</u>	<u>51453.67000</u>	<u>-8738.75000</u>	<u>-16.9840%</u>
<b>Net Ordinary Income</b>	<u>8898.7000</u>	<u>-5767.05000</u>	<u>14665.75000</u>	<u>-254.3020%</u>
<b>Net Income</b>	<u><u>8898.7000</u></u>	<u><u>-5767.05000</u></u>	<u><u>14665.75000</u></u>	<u><u>-254.3020%</u></u>