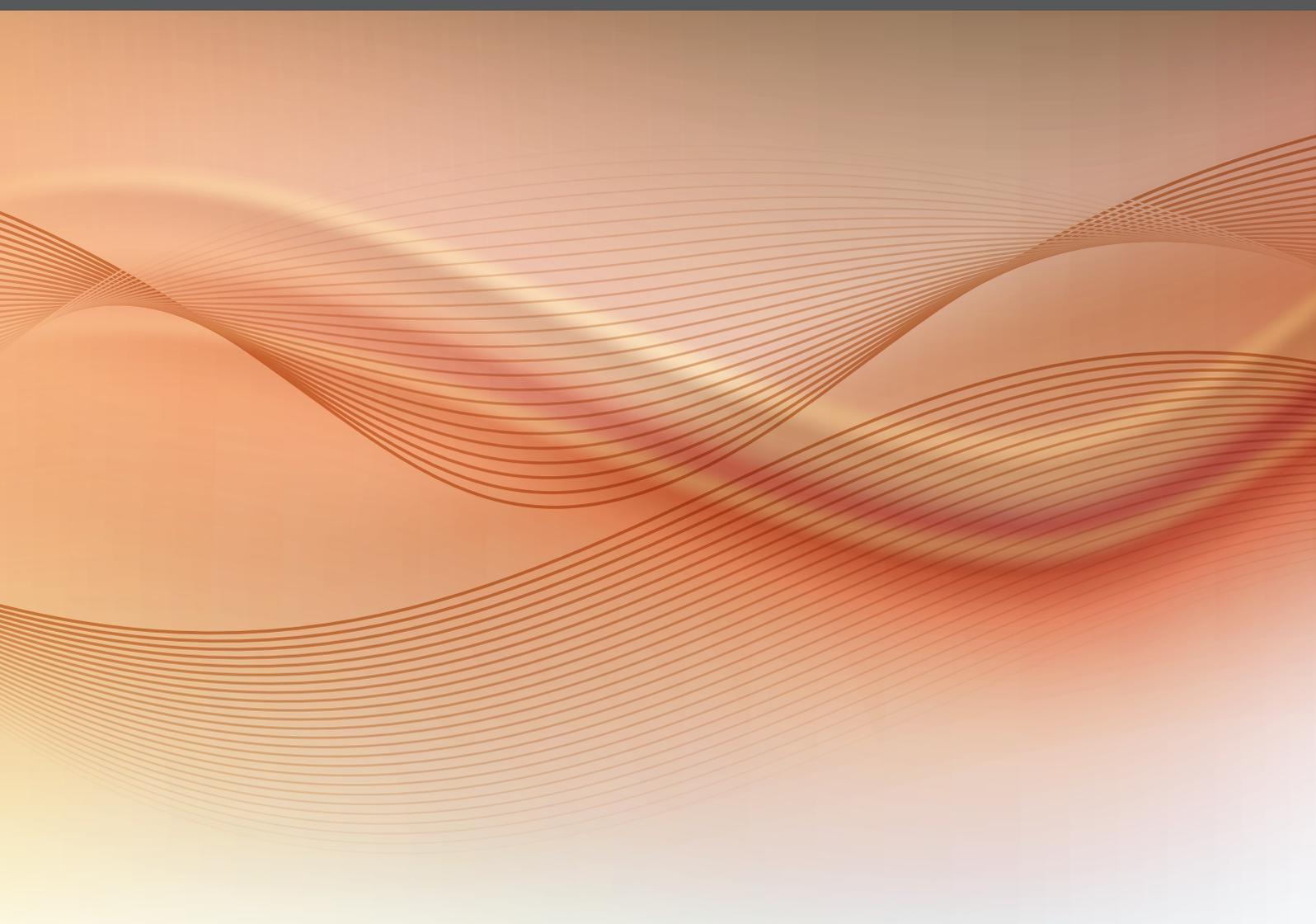


# Australian Society of Anaesthetists

ANNUAL REPORT | 2015



## Objectives of the Australian Society of Anaesthetists

- Advance the science and art of anaesthesia and related disciplines in Australia to achieve international best practice
- Promote education and training in anaesthesia and related disciplines
- Prescribe high standards of practice and professional conduct and maintain the objects of such standards
- Encourage and support research related to anaesthesia
- Publish a scientific journal and encourage other publications in the sphere of anaesthesia
- Facilitate communication between practitioners in anaesthesia and related disciplines
- Enhance the professional status of anaesthesia
- Preserve, at all times, the professional independence of anaesthetists in whatever capacity they may be serving
- Protect the economic and legal interests of anaesthetists
- Work effectively with other medical organisations
- Foster the personal health and welfare of members, associates and their families
- Encourage the preservation of history related to anaesthesia
- Do all such other things as may be incidental to or conducive to the attainment of the above objects

## VISION

To support, represent and educate our members to enable the provision of the safest anaesthesia to the community.

## MISSION

To enable medical practitioners in the specialty of anaesthesia to achieve best practice in the following:

- Safe, high-quality patient care
- Engagement in planning and delivering healthcare services
- Compliance with medical obligations
- Continuing Medical Education, research and publications
- Personal health and welfare
- Leading advocacy on economic, industrial and workplace issues
- Philanthropic service and contribution to the developing world
- Preservation of the history of the specialty

## STRATEGIC PRIORITIES

- Promote the needs of the specialty in both the public and private sectors to government and other authorities.
- Provide a broad range of high-quality educational services, resources and opportunities for members.
- Actively address the professional and economic issues that impact on members in public and private practice in urban, regional and remote Australia.
- Actively support services in the provision of overseas development and education.
- Ensure the Society is governed in such a manner that complies with all statutory obligations while serving the interests of members.

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# President's Message

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It is with great pleasure that I bring you the President's Report for 2015.

Let me at the outset reassure you, that the Society is strong, vibrant and, after a successful year, looks with great optimism and enthusiasm towards the next one.

## OBJECTIVES AND STRATEGY

The objectives of the ASA have not changed since the last Annual Report and remain in accord with the Constitution.

## VISION

Support represent and educate our members to enable the provision of the safest anaesthesia to the community.

## MEMBERSHIP

A key focus for the Board of Directors in the last year has been on membership. Self evidently, no Society such as ours can continue unless it has the support of its members and a firm financial footing on which to work. At a time when many membership based organisations are seeing declining numbers, we are most grateful for the unwavering support of our core 'ordinary' members. Our renewal rate remains at around 96%. Many thanks indeed to our rather 'extra-ordinary' members!

Membership of the company increased from 3,181 to 3,249 (2.1%) during the financial year, reflecting ongoing support for the Society and its objectives. The company achieved a surplus after expenses of \$1,352,771 compared to \$2,086,657 for the preceding financial year.

We are however, committed to growing our membership and would hope to see a situation in Australia where every anaesthetist who is eligible, is an ASA member and a Fellow of the College. And those who, for a variety of reasons are not, Fellows still find a home in the ASA. We would seek to meet the needs of our GP anaesthesia colleagues who play a key role in providing services in areas not serviced by a specialist workforce.

We have put in place a number of initiatives to specifically target non-members and to appeal to those whose membership might have lapsed. Whilst we recognise

that such specific marketing strategies are vital for an organisation's success, we are hopeful that our most powerful 'inducement' for members to join and remain with us is the work we do on your behalf and the sense of unity and collegiality enjoyed by belonging to a thriving, vibrant and well-represented specialty.

## BOARD OF DIRECTORS

### Constitution and governance

The Board are examining whether our current constitution and governance structure is the best model for a modern organisation and changes are being considered to how we conduct our business. We need our office bearers to be clear in their roles and responsibilities and our members to be confident that not only is the business of the Society being attended to, but that their views and the views of their state are represented.

### Funds and investments

In keeping with our strategic direction, it was felt that a new approach to our funds and investments was needed in order to ensure the best possible stewardship and governance arrangements for these resources. The CEO and Treasurer nominated Credit Suisse as the organisation to entrust with our funds and the Board has approved this.

It is a relief in these uncertain and slightly 'bearish' times to have the funds under good management and with as many protections as we can reasonably ensure.

The Society achieved a strong financial result under the stewardship of Dr Andrew Miller with a surplus of \$1,352,771.

## COMMITTEES

The ASA has a large number of committees who provide advice to the Board and achieve much of the work of the ASA. The valuable input and commitment to the work of the ASA benefits and reflects well on all members. Our Committees have also had a very productive year – some of the highlights are:

## Professional Issues Advisory Committee (PIAC)

Chaired by Dr Jim Bradley until July 2015, and now headed by Dr Antonnio Grossi, some of the activities included:

### Membership assistance

This remains a key area of PIAC on a daily basis. Key areas included clinical privileges, credentialing, provision of on-call behavioural concerns, occupational health and safety.

### Submissions

There was extensive consultation and collaborations amongst the committee on a broad range of documents, these included:

- ANZCA PS07 Pre-anaesthesia assessment
- AHPRA Cosmetic surgery. Liaised with Australian Society of Plastic Surgeons and AMA.
- ACCC (Medicines Code of Conduct)
- AHHA (National Competency Standards Framework for Pharmacists)
- HPA (Teaching, Training and Research costing study public consultation)

### Advocacy and engagement: Political

The Society, through PIAC continues to work in close association with the AMA. It has worked with the AMA to get anaesthesia workforce issues firmly onto the agenda of NMTAN. It has also engaged with the AMA on the MBS Review and sent a delegation to the AMA meeting on the Review. It is the intention of the Society to work closely with the AMA on the Review and to interact very actively with it.

The AMA National Conference provided the Society with a wonderful opportunity for information sharing and insights into the broader issues facing the profession. It specifically offered a unique moment to inform the profession of the pending changes to the VA Nursing Handbook with the potential for fully independent practice within the VA of nurse anaesthetists and other mid-level providers such as midwives and nurse practitioners.

### Workforce

The Society has been actively involved in this area, which resulted in a very productive meeting with NMTAN and a comprehensive exchange of data and ideas with Maureen McCarty (Director of Data, Analysis & Planning; Commonwealth Department of Health). The Society is very grateful to Jim Bradley and Richard Grutzner who have been steadily accumulating data and expertise in this area over many years.

## Economic Advisory Committee (EAC)

Dr Mark Sinclair, as Chair of the Economics Advisory Committee (EAC), has again had a very busy and productive 12 months.

### MSAC

The EAC has continued to tirelessly advocate on behalf of the membership.

### MBS review

We have attended two consultation meetings with the Chair of the review, Professor Bruce Robinson.

The more recent meeting in Canberra included a briefing by the AMA President.

Associate Professor Brian Owler was of the view that we need to organise ourselves to get the best outcome from the MBS review.

He refuted the notion that expenditure was out of control and that the system has in fact managed to squeeze providers on price. He would argue that the government has levers to control price such as the rebate freeze and that the role of the profession in this instance is to advise government and private health insurers on how to spend more wisely.

He urged the profession to be coordinated in its approach and to avoid any chance of the government picking off the specialities one by one. It is anticipated that there will be 80 to 100 reviews occurring at any one time and the AMA will develop an information-sharing tool to coordinate the effort.

Professor Bruce Robinson, Chair of the MBS Review Taskforce has stated that one of his objectives in addressing the meeting was to allay concerns of people and to reassure them that he is aware that people are sensitive and wary about this process and that many are running small businesses and see major risks to these.

Fundamentally, the government are not happy with the trajectory of health care spending and, in particular, an increase in the number of services.

He was of the view that it is in fact about modernising the MBS, eliminating items not consistent with best practice, eliminating rebates that are inappropriate for the procedure and is about a need to realign value.

His planned approach is to engage stakeholders and to set up a number of interdisciplinary clinical review teams. One of the principles guiding the set-up of these teams will be to avoid having a majority of any one discipline on the team.

In the first instance, the review intends to undertake a series of rapid reviews as per the Ontario process developed in Canada. This is quite distinct from any MSAC process.

The ASA will continue to engage with this very important process and will be ensuring it has a place in any review of anaesthetic item numbers and strive to ensure that the review has a full appreciation of the relative value approach adopted by anaesthesia to its billing. We are confident that, with the economic expertise we have in the Society, together with the modern and contemporary approach to billing utilised within our RVG that we will be able to make any adjustments required to 'modernise' our descriptors and justify why and where we add value.

### Private Health Insurers: Medibank Private

The protracted and difficult negotiations between Medibank Private (MBP) and Calvary Health Care (CHC) have ignited a debate about the appropriate approach to patient safety and quality within the private health care sector, and in Australia more broadly.

Despite five months of discussions, MBP and CHC struggled to reach agreement and renew their contract. MBP claims that they have been working to reduce

adverse events, improve outcomes and reduce unnecessary costs. But CHC did not agree with their approach.

*What was their approach that was so unacceptable to CHC?*

The new approach adopted by MBP was one of financial penalties levied for failure by CHC to prevent a list of 165 highly preventable adverse events. The premise presumably being that, by doing so, they would compel CHC to improve the processes, policies and behaviours that lead to these events; and in doing so there would be a reduction in the incidence of these leading to better outcomes and reduced costs.

This is a significant paradigm shift in the approach to patient safety and quality and it must be asked whether such an approach has been scientifically validated?

It is just possible that this approach is flawed and it might bring about quite the opposite effect? Not only might it fail to improve safety, but also distort the very 'culture' and conditions needed for the open and transparent examination of adverse and sentinel events and result in the unjustified punishment and sanction of both organisations and individuals involved in patient care.

The ASA is concerned that the punitive approach of MBP has no place in the contemporary approach to improving safety and quality.

In the view of the ASA, no patient should have to fear that they will be 'abandoned' by their insurer at the time of their greatest need and vulnerability.

The Society is meeting with the new Chief Medical Officer of MBP, Dr Linda Swan, and we would hope to have an open and frank discussion about the approach that MBP have taken to safety and quality.

We are also in touch with the College via the Safety and Quality Committee and are aware that the President will be meeting as well with MBP. The College shares our concerns about

this new direction that MBP have taken and will be conveying this to the organisation

#### Private Health Insurers: HCF

The Society had recent fruitful discussions with these two organisations concerning a range of issues.

The discussions with HCF mainly revolved around the differences between their No Gap and Known Gap product and the differences in value assigned to various item numbers. The doctor must choose one or the other and is not able to change systems on a patient-by-patient basis. It was emphasised to HCF that the ASA is philosophically wedded to the notion of the value of an anaesthetic being determined by the units accruing to it and that in general principle the RVG unit dollar value should be the same, irrespective of the procedure. Fourteen RVG items in the no-gap scheme are currently rebated at a higher level. The meeting was a very useful opportunity to explain in more detail how the RVG worked and to share copies of our RVG with the delegation. The current HCF system will be reviewed to assess its uptake and success.

#### Private Health Insurers: NIB

This meeting was held in response to many members concerns regarding the Medigap Scheme's terms and conditions.

NIB took on board our concerns regarding the various requirements pertaining to audit, patient confidentiality and rules concerning staff specialists. NIB has committed to reviewing the terms and conditions and we await their feedback.

#### Overseas Development and Education Committee (ODEC)

This committee works tirelessly under the Chairmanship of Dr Rob McDougal on a range of valuable anaesthesia activities in the field of humanitarian work, with the delivery of programs in countries such as Laos, Cambodia, Bhutan and a number of Pacific Islands. Such work is greatly valued and the Society should be proud of its significant support for the initiatives undertaken. At the same time, through the "Life Box" program, Dr McDougall and his team are able to provide much needed pulse oximeters in areas of great need.

#### Group of ASA Clinical Trainees (GASACT)

The GASACT committee is an enthusiastic group of young trainee anaesthetists who are contributing to the work of the ASA and providing educational opportunities and activities for trainees. We thank Dr Ben Piper who has been at the helm of this Committee.

#### Communications Committee

Dr Greg Deacon heads the Communications Committee and can report that the *Australian Anaesthetist* magazine remains increasingly popular in so much as the magazine will be published on a quarterly basis commencing in 2016. Greg has ensured that communications such as the magazine and the President's enews are delivered to members in the most efficient, relevant and technology savvy manner.

#### Membership Committee

Headed by Dr Andrew Schneider until recently, the membership committee's role is to streamline the membership application process and to initiate activities which will encourage new members.

#### ACECC

The Society continues to work with ANZCA to ensure the value and relevance of this important entity which 'houses' the shared resources of the two bodies, e.g. the Special Interest Groups, and through which conferences and other CPD activities are coordinated. It is intended to rebrand and re-invigorate ACECC in the coming year.

#### COUNCIL OF PROCEDURAL SPECIALISTS

We continue to work closely with the Council of Procedural Specialists (COPS) and were able to meet with the Minister, Sussan Ley, as part of a COPS delegation. It provided an opportunity to discuss with the Minister's office the potential issue of an oversupply of doctors and the large number of medical students needing training. The Minister's office was certainly aware of the work of NMTAN.

## **AUSTRALIA AND NEW ZEALAND COLLEGE OF ANAESTHETISTS**

The Society has determined to work closely with ANZCA on all matters of mutual interest and significance to the speciality. It will meet with the College and have discussions on a range of topics to find common ground and to ensure that the specialty's interests are comprehensively represented and protected by both organisations.

## **COMMON ISSUES GROUP**

The Common Issues Group meeting held in Washington was a highlight of our international interaction and continues to deliver benefits to members of all the representative organisations. This interaction continues to grow and consolidate and the ASA Meeting in Darwin, and the ASA (USA) meeting to follow in San Diego will provide ongoing forums for discussion and dissemination of information. The Society is well advanced in its preparations to host this meeting in Hong Kong in advance of the WCA in 2016.

The ASA (USA) Legislative Conference in Washington highlighted the need for our specialty to be prepared for and engaged in advocacy to demonstrate the value and expertise we bring to patient care as physician anaesthetists.

## **NEW ZEALAND SOCIETY OF ANAESTHETISTS**

The relationship between the ASA and NZSA remains as strong as ever and was exemplified by the recent Combined Scientific Conference. I would like to extend our thanks and appreciation to all our members to our New Zealand counterparts for their ongoing commitment to the specialty; and to preserving the highest anaesthesia standards. Our relationship with NZSA provides us with insights, information and interaction with outstanding colleagues.

## **'BOOJUMS' MEETING, SOUTH AUSTRALIA**

There is an urgent need to continue to examine our role as perioperative physicians and this role was highlighted in the important 'Boojums' Meeting organized by the ASA in Adelaide in February this year. This meeting was in response to the coronial inquest into the perioperative deaths of two patients in a smaller private hospital in Adelaide. The meeting drew together representatives from a wide range of specialties and professions and was a credit to the leadership and initiative of the ASA in South Australia. The Society has been actively engaged with the College in the process of redrafting key professional statements relevant to the matters raised in the coronial report and highlighted at this meeting.

## **ANAESTHESIA AND INTENSIVE CARE**

Under the leadership of Dr Neville Gibbs, the Society remains very proud to be the 'owner' of the specialty's academic journal, *Anaesthesia and Intensive Care*. This is a vital academic tool for the speciality and offers a wonderful opportunity for researchers to get their material published. Anaesthesia research in Australia is very well established and enjoys world-wide recognition for its excellence and clinical relevance. The speciality

will require an ongoing intellectual basis for what it does and to demonstrate, not only the improvement in safety from its initiatives, but also the validity, value and cost-effectiveness of what it does.

The Society continues to benefit from the extraordinary, selfless work of its many members.

I would urge you join with us in striving for an ASA that represents every single anaesthetist and where the question 'why should I become a member' is replaced with why on earth are you not a member?!

*Dr Guy Christie-Taylor*

*ASA President*

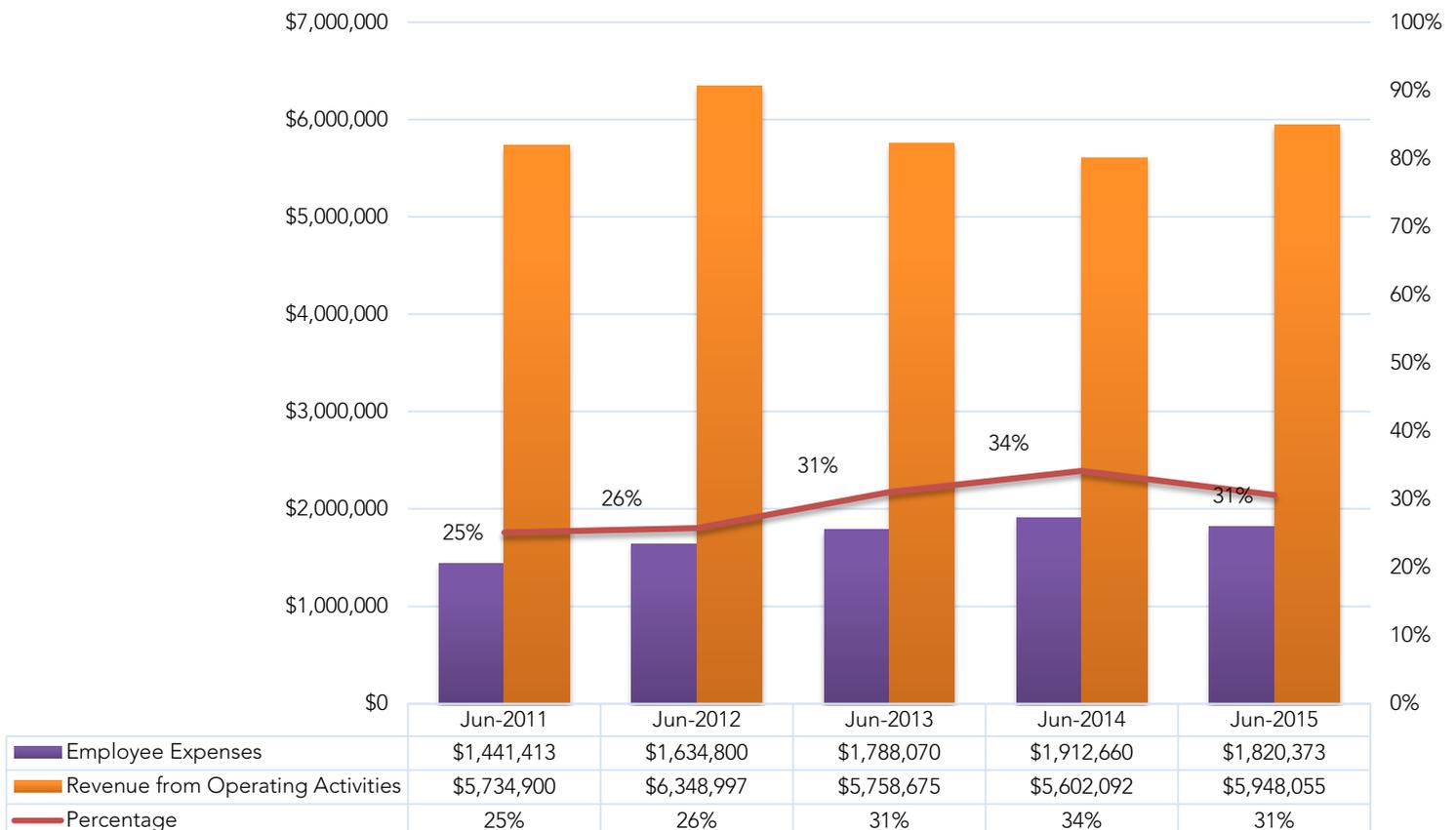
# Summary Financial Statement 2014/2015

## ASA Benevolent Trust Fund

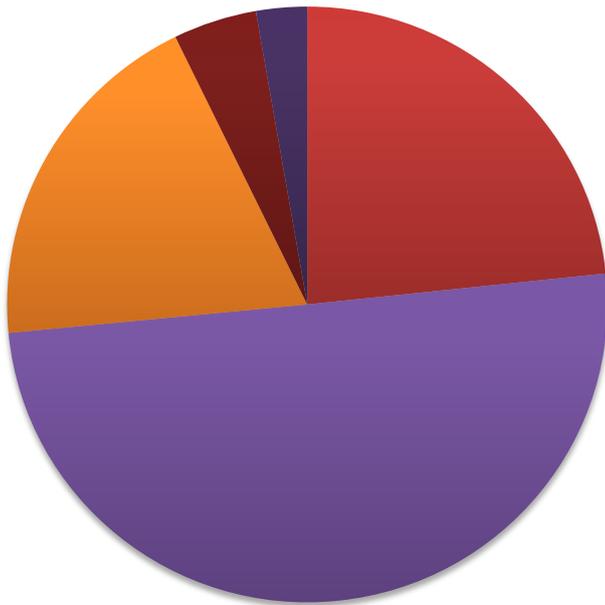
The ASA Benevolent Trust Fund was established in 2001 to assist Australian anaesthetists, their families and dependants who are in dire necessitous circumstances. The Trust Fund is maintained exclusively from members' donations and interest on the balance of the fund. In the 2014/15 financial year, the Trust Fund received \$2,700 in donations. The ASA would like to thank all those who generously contributed to this worthy cause.

<b>Trust Fund opening balance, 1 July 2014</b>	<b>\$43,992</b>
Less: Outgoings (bank charges)	\$0
Payments	\$0
Add: Donations	\$2,700
Interest	\$1,190
<b>Closing balance, 30 June 2015</b>	<b>\$47,882</b>

## Percentage of Employee Expenses to Operating Revenue

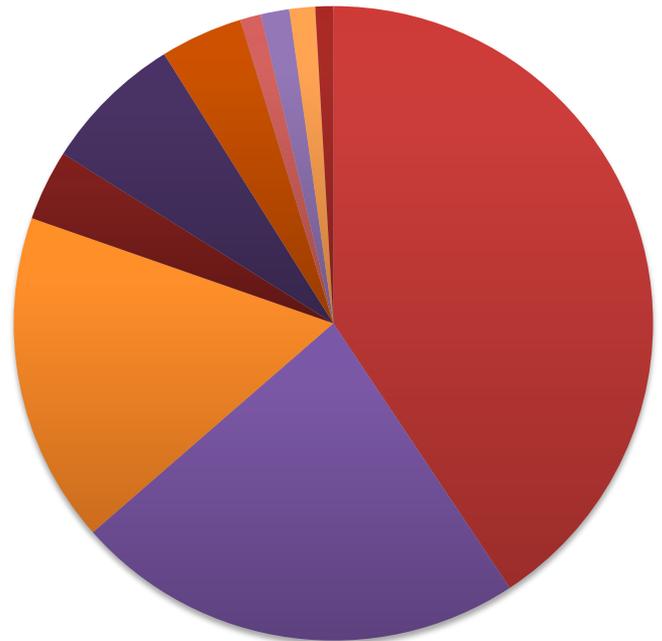


## Assets



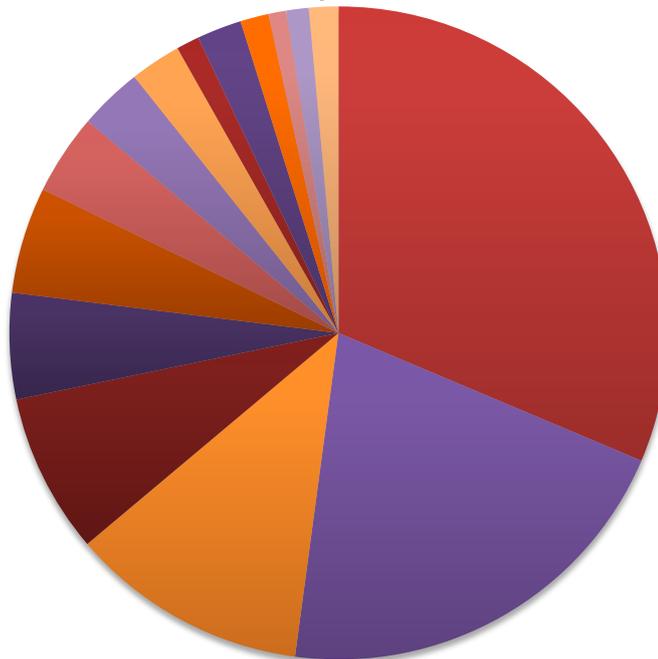
- Cash and Term Deposits 23%
- Managed Funds & Subordinated Notes 50%
- Building 19%
- Debtors 4%
- Other Assets 3%

## Income Sources



- Membership 41%
- NSC Gold Coast 23%
- Investment 17%
- Joint CMEs 7%
- Joint SIGs 4%
- AIC 4%
- Rental Income 1%
- CME run by ASA 1%
- Advertising 1%
- Other 1%

## Expenditure



- Salaries 31%
- Joint CMEs SIGs 12%
- Property & IT 5%
- Other 4%
- Depreciation 3%
- Printing, Postage & Stationery 2%
- Awards 1%
- Doubtful Debts 1%
- NSC Gold Coast 21%
- Honoraria 8%
- Travel 5%
- AIC Journal 3%
- Legal & Professional 1%
- ODEC 1%
- Branch Offices 1%

AIC=Anaesthesia and Intensive Care, CME=continuing medical education, NSC=National Scientific Congress, SIG=Special Interest Group, ODEC=Overseas Development and Education Committee.

**SUMMARY FINANCIAL STATEMENT 2014/2015**

<b>BALANCE SHEET</b>	<b>2015</b>	<b>2014</b>
	\$000s	\$000s
<b>ASSETS</b>		
<b>Current assets</b>		
Cash and cash equivalents	590	2,021
Receivables	980	853
Other financial assets	15,431	13,077
Other current assets	435	504
	17,436	16,455
<b>Non-current assets</b>		
Property, plant and equipment	4,323	4,414
Other non-current assets	46	46
	4,369	4,460
<b>Total assets</b>	<b>21,805</b>	<b>20,915</b>
<b>LESS LIABILITIES</b>		
<b>Current liabilities</b>		
Payables	2,990	2,915
Employee benefits	110	84
	3,100	2,999
<b>Total liabilities</b>	<b>3,100</b>	<b>2,999</b>
<b>Net assets</b>	<b>18,705</b>	<b>17,916</b>
<b>Accumulated funds</b>		
Retained surplus	18,702	17,350
Fair value reserve	3	566
<b>Total accumulated funds</b>	<b>18,705</b>	<b>17,916</b>
<b>INCOME STATEMENT</b>		
<b>REVENUE</b>		
Revenue from operating activities	5,948	5,602
Financial income	1,203	781
Net gain on sale of property, plant and equipment	-	1,514
<b>Total revenue</b>	<b>7,151</b>	<b>7,897</b>
<b>LESS EXPENSES</b>		
ANZTA Data Collection	81	78
Awards	51	74
Computer expenses	163	210
Conferences and meetings	2,185	2,065
Cost of sales— <i>Anaesthesia and Intensive Care</i> journal	181	186
Depreciation expenses	146	138
Doubtful debts	84	45
Employee expenses	1,820	1,913
Honoraria	459	411
Legal and professional fees	65	130
Overseas Development and Education Committee	81	90
Printing, stationery and postage	127	112
Property costs	141	142
Secretariat expenses	64	60
Other expenses	150	156
<b>Total expenses</b>	<b>5,798</b>	<b>5,810</b>
<b>Surplus from ordinary activities</b>	<b>1,353</b>	<b>2,087</b>

Full copies of the Financial Statements including Director's Report and Declarations and Auditors' Report may be obtained from the CEO, Australian Society of Anaesthetists Limited, PO Box 6278, North Sydney NSW 2059

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