AMA

ANNUAL REPORT

2020

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Australian Medical Association Annual Report 2020
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PRESIDENT'S **REPORT**

DR OMAR KHORSHID
Federal AMA President

> It's a privilege to be providing this advice to our nation's leaders on behalf of AMA members, more so because the path out of the pandemic is becoming clearer.

2020 was an extraordinarily difficult year for the community and the medical profession. As doctors, COVID-19 threatened our personal health and the health of our families. It threatened our livelihoods. It caused incredible disruption in almost every aspect of our lives and will do so for some time yet.

The AMA led the profession in advocating early and hard for appropriate actions to control the spread of the virus, with the safety of frontline healthcare workers at the forefront of our actions at all times.

Dr Tony Bartone, my predecessor as federal president, led the initial AMA response to the emerging pandemic. With passion and a non-stop work ethic, Tony spoke to media, to government, and to the Australian public to help steer Australia through the early stages of the COVID-19 period. He did so on the back of having been one of the leading medical voices in response to the 2019–2020 summer bushfire tragedy that decimated communities up and down the east coast, and triggered respiratory illness in cities far from fire fields as smoke lingered over capitals for weeks on end.

COVID-19 restrictions meant the transition of presidency from Tony to me was not what either of us would have hoped for. A virtual instead of in-person election saw me take up office on 1 August, with Tony on Zoom in Melbourne handing the presidential reins to me in Perth.

The newly elected AMA Federal Council, quickly adopted a COVID-19 communique which continues to serve AMA advocacy to this day. The communique and our subsequent actions have:

- reinforced the need for ongoing vigilance and social distancing to minimise the risk of lockdowns in the inevitable event of further outbreaks arising from breaches to quarantine.
- promoted health care worker safety;
- secured General Practice as the key method of COVID-19 vaccine distribution;
- used the AMA's respect by the general public to reject misinformation and assure trust and confidence in a medical pathway out of the pandemic.

Having attended National Cabinet, having met with the Prime Minister and his Health Minister, and having regular ongoing contact with Secretary of the Commonwealth Health Department and his senior leadership team, the AMA more than any other health body has been sought out and listened to for medical advice. It's a privilege to be providing this advice to our nation's leaders on behalf of AMA members, more so because the path out of the pandemic is becoming clearer. Our special COVID-19 response report details our work over the year on the pandemic.

Extraordinarily, COVID-19 has not dominated the AMA's entire agenda over the last year. In part because of such a committed and professional Federal AMA staff team, together with a Federal Council that has met every six weeks in response to the health crisis, we have been able to advance non-COVID-19 issues on behalf of AMA members. Our advocacy highlights and AMA advocacy sections detail this work.

My thanks

My federal presidency to date, and the latter part of Tony Bartone's presidency, have been unlike any before. I've only been able to travel to our secretariat in Canberra from my home in Perth once to date. Even then it was with uncertainty of changing border restrictions.

Uncertain border and travel restrictions have meant the Federal Council, the Federal Board, and the Federal Secretariat staff team have had to work differently. We Zoom-meet rather than fly in to meet, with Microsoft Teams and Slack our new normal.

Having been forced to a new normal so rapidly, while every member of Federal Council, the Federal Board and Federal Secretariat staff team were also dealing with the personal pressures of the global pandemic, it's amazing the work flow of the AMA has not missed a beat. The AMA's work on behalf of its members has increased in both volume and importance, in response to the impact of the pandemic.

I'm grateful to all in the AMA who have gone above and beyond professional and volunteer norms. I'm grateful to federal Vice President Dr Chris Moy in particular for being the lead GP voice in response to the pandemic.

While not able to be in the same room, the AMA elected and staff leadership has been united by the same commitment to ensure the AMA has done all it can in the last year to help doctors and their patients survive and thrive through the pandemic. We'll do the same in the year ahead, as slowing down is not an option.

Dr Omar Khorshid

Federal President
Australian Medical Association Limited

> The AMA's work on behalf of its members has increased in both volume and importance, in response to the impact of the pandemic.

CHAIR OF THE BOARD'S **REPORT**

ASSOCIATE PROFESSOR GINO PECORARO
AMA Board Chair

At the start of 2020, the Board of AMA Ltd adopted a new strategic plan. The plan's four drivers are:

1 Value for Members
2 Focused Advocacy
3 Effective and Efficient Operations
4 Improved Federation

The new strategic plan is built on the necessity of rethinking the Federal AMA's business model. Every organisation or commercial business needs to reset strategy and operations from time to time. The AMA is no different.

Accordingly, we set about adjusting the federal AMA's cost base that had grown beyond future revenue forecasts. We made changes to recurrent expenses, changes to our property strategy, and took action to ensure our three subsidiary companies; AMPCo, doctorportal Learning Pty Ltd, and Doctors Health Services Pty Ltd are each weaned off recurrent subsidies from AMA Ltd and not only break even by the end of the current strategic plan, but actually contribute to the future viability of the AMA Group of companies.

> "Our elected leadership and staff teams put their usual business on hold and pivoted to ensuring Australia's health system and community was able to survive the global pandemic.

As the new strategic plan was being implemented, COVID-19 became the organisation - and the world's - priority. Our elected leadership and staff teams put their usual business on hold and pivoted to ensuring Australia's health system and community was able to survive the global pandemic. The AMA's relevance, and its workload, skyrocketed through the last year. We proved the AMA is at its best when responding to the health needs of the nation's medical profession and community members they care for.

After the peak period of COVID-19 uncertainty, work-from-home requirements for our staff, and state and territory border restrictions that to this day prevent the elected leadership from regular travel, work resumed on our strategic plan. The staff team has been reorganised, with campaign, research, and economic capability now embedded. The three subsidiaries each have new operational targets, with AMPCo shifting to digital communication away from print, doctorportal Learning being operated in partnership with AMA WA, and Doctors Health Services having been independently reviewed and a new business model designed.

Importantly, COVID-19 did not dent financial performance. The AMA group of companies recorded a consolidated total comprehensive income of $2.3 million for the year. A portion is Commonwealth contributions to stave off the COVID-19 recession risk. Another portion is operational savings arising from travel restrictions. Yet the result also includes recurrent efficiency from changes to our cost base and improved commercial performance from business change at AMPCo. These business efficiencies within the federal AMA and AMPCo will serve the business for years to come.

The presidents and vice presidents who have served throughout the last twelve months, the members of the AMA Board, the staff team of the Federal Secretariat and our subsidiaries AMPCo, doctorportal Learning, and Doctors Health Service, have each had a challenging year but have contributed over and above what could have been expected in light of lock downs, working-from-home, and COVID-19 uncertainty. AMA members can be proud their elected leaders and staff have acted in their best interests, and the AMA's results on behalf of the medical profession over this last year support this assessment.

> "AMA members can be proud their elected leaders and staff have acted in their best interests.

A/Prof Gino Pecoraro
Chair
Australian Medical Association Limited

Strategic Plan 2020-2023

Leading Australia's Doctors, Promoting Australia's Health

VALUE FOR MEMBERS

- Membership benefits measured by satisfaction survey
- Harmonised federal and state and territory communication
- Deeper transparency on advocacy through annual report
- Expand member digital participation in shaping policy
- Response to individual member issues, measured by reporting on member problem resolutions

FOCUSED ADVOCACY

- Create a long-term vision for Australia's health system
- Focused campaigns targeting improvements for doctors, patients, and Australia's health care system
- Council, Taskforce and Committee annual advocacy plans informed by patients
- AMA brand enhancement; growth in media share of voice
- Costed proposals coinciding with Federal Budget cycle
- Planned capability for unforeseen threats to effective health care provision
- Leading collaborations with strategic partners, measured by effecitveness of partnership

IMPROVED FEDERATION

- Focus on nationally relevant advocacy; Board review of resource allocation
- Operations funded by available revenues, measured against annual financial targets
- Investment income preserved for future, measured against annual financial targets
- Growing commercial subsidiaries, measured by contribution to AMA revenues
- Plan for future non-member income
- Social and economic responsibility across the AMA against Board targets
- Improved Secretariat capability for member outcomes

EFFECTIVE & EFFICIENT OPERATIONS

- Streamlined roles: federal focus on national advocacy. State and territories delivery of federation advocacy campaigns
- Enable member jurisdictional industrial coordination
- Jurisdictional expertise delivering shared services and shared member benefits in the federation
- Respectful, trusting, collaborative culture across federation. Measured by annual survey of state and territory president and CEOs.
- Determine accountabilities of federal, state, and territory bodies

LEADERSHIP
AMA BOARD
FROM 18 JUNE 2020


Dr Omar Khorshid, President


Dr Chris Moy, Vice President


Associate Prof. Rosanna Capolingua


Dr Antonio Di Dio


Dr Bavahuna Manoharan


Dr Helen McArdle


Dr Kate Kearney


Associate Prof. Gino Pecoraro, Board Chair


Dr Gary Speck


Associate Prof. William Tam


Dr Stephen Gourley

FEDERAL COUNCIL FROM 1 AUGUST 2020	
Dr Omar Khorshid	President
Dr Chris Moy	Vice President
Associate Professor Julian Rait	Federal Council Chair
Associate Professor Gino Pecoraro	Board Chair
AREA NOMINEES	
Adjunct Professor Janice Bell	WA
Dr Dilip Dhupelia	QLD
Dr Jill Tomlinson	VIC
Dr Michelle Atchinson	SA/NT
Dr Tessa Kennedy	NSW/ACT
Dr Annette Barratt	TAS
SPECIALTY GROUP NOMINEES	
Dr Andrew Miller	Anaesthetists
Dr Chris Baker	Dermatologists
Dr Sarah Whitelaw	Emergency Physicians
Professor Steve Robson	Obstetricians and Gynecologists
Dr Peter Sumich	Opthamologists
Dr Sarah Coll	Orthopaedic Surgeons
Dr Paul Bauert	Paediatricians
Dr Daniel Owens	Pathology
Dr Matthew McConnell	Physicians
Associate Professor Jeffrey Looi	Psychiatrists
Dr Brendan Adler	Radiologists
Professor Owen Ung	Surgeons
PRACTICE GROUP NOMINEES	
Dr Mohamed Hashim Abdeen	Council of Doctors in Training
Dr Richard Kidd	Council of General Practice
Dr Marco Giuseppin	Council of Rural Doctors
Associate Professor Julian Rait	Council of Private Specialist Practice
Dr Roderick McRae	Council of Public Hospital Doctors
STATE NOMINEES	
Dr Antonio Di Dio	ACT
Dr Danielle McMullen	NSW
Dr Chris Perry	QLD
Dr Enis Kocak	VIC
Dr Mark Duncan-Smith	WA
Associate Professor Robert Parker	NT
Dr Hannah Szewczyk	SA
Dr Helen McArdle	TAS
AIDA REPRESENTATIVE	
Dr Kris Rallah-Baker and Dr Tanya Schramm (from 1 Dec)	
AMSA REPRESENTATIVE	
Mr Daniel Zou	
ASMOF REPRESENTATIVE	
Professor Geoffrey Dobb	

LEADERSHIP
AMA BOARD
UNTIL 17 JUNE 2020


Dr Tony Bartone, President


Dr Chris Zappala, Vice President


Associate Prof. Rosanna Capolingua


Associate Prof. Gino Pecoraro


Dr Bavahuna Manoharan


Dr Helen McArdle


Dr Danielle McMullen


Dr Iain Dunlop,
Board Chair


Dr Gary Speck


Associate Prof. William Tam


Dr Stephen Gourley

FEDERAL COUNCIL UNTIL 31 JULY 2020	
Dr Tony Bartone	President
Dr Chris Zappala	Vice President
Dr Andrew C Millar	Federal Council Chair
Dr Iain Dunlop	Board Chair
AREA NOMINEES	
Adjunct Professor Janice Bell	WA
Dr Shaun Rudd	QLD
Dr Jill Tomlinson	VIC
Dr Chris Moy	SA/NT
Associate Professor Saxon Smith	NSW/ACT
Professor John Burgess	TAS
SPECIALTY GROUP NOMINEES	
Dr Andrew J Miller	Anaesthetists
Dr Andrew C Miller	Dermatologists
Associate Professor David Mountain	Emergency Physicians
Professor Steve Robson	Obstetricians and Gynecologists
Dr Brad Horsburgh	Ophthalmologists
Dr Omar Khorshid	Orthopaedic Surgeons
Dr Paul Bauret	Paediatrics
Dr Ben Rowbotham	Pathology
Professor Mark Khangure	Radiologists
Professor Owen Ung	Surgeons
Dr Matt McConnell	Physicians
Professor Steve Kisely	Psychiatrists
PRACTICE GROUP NOMINEES	
Dr Tessa Kennedy	Council of Doctors in Training
Dr Richard Kidd	Council of General practice
Dr Sandra Hirowatari	Council of Rural Doctors
Associate Professor Julian Rait	Council of Private Specialist Practice
Dr Roderick McRae	Council of Public Hospital Doctors
STATE NOMINEES	
Dr Antonio Di Dio	ACT
Dr Kean Seng Lim	NSW
Dr Dilip Dhupelia	QLD
Dr Will Blake and Dr Sarah Whitelaw	VIC
Dr Mark Duncan-Smith	WA
Associate Professor Rob Parker	NT
Associate Professor William Tam	SA
Dr Helen McArdle	TAS
AIDA REPRESENTATIVE	
Dr Kris Rallah-Baker	
AMSA REPRESENTATIVE	
Ms Jessica Yang	
ASMOF REPRESENTATIVE	
Professor Geoffrey Dobb	

COVID-19 RESPONSE **REPORT**

COVID-19 was first identified in December 2019 and Australia's first case appeared on 25 January 2020. It was the harbinger of a year characterised by outbreaks, lockdowns and 909 deaths.

The AMA responded swiftly and assembled a COVID-19 policy response team. Its immediate focus was the safety of frontline healthcare workers and prevention of community transmission.

In March the AMA declared COVID-19 a national public health emergency and called for social distancing and an immediate ban on mass gatherings.

Going to work became a life-threatening risk for medical and health workers and the AMA recognised the need for the best possible information and equipment to protect them.

AMA pushed for the involvement of the medical profession at all levels in planning and disseminating public health messaging. It warned states to prepare for school closures, home schooling and working from home.

The AMA worked with State and Federal Governments to bring in appropriate restrictions and border controls. As the pandemic engulfed and dominated the media, the federal President and Vice President became the top national voices of reason responding to COVID-19.

After years of AMA advocacy for telehealth, COVID-19 presented the perfect opportunity for its adoption, offering contact-free consultation, reducing community transmission and conserving scarce personal protective equipment (PPE). By May, 10 million Medicare funded telehealth services had been provided and AMA convinced the Federal Government to cover temporary rebates for telehealth consultations.

Aged care settings posed a deadly risk for the elderly with 630 of Australia's COVID-19 deaths in 2020 occurring in nursing homes. The AMA called for residential aged care centres to publish action plans for concentrated virus outbreaks.

The AMA worked with Government and the private health sector to produce the Private Hospital Guarantee where the Australian Government backed the private hospital sector with funding in return for the sector making private hospital beds and its workforce available to work with the public hospital sector in addressing COVID-19.

Widespread restrictions of movement, physical isolation and lockdowns took their toll on the nation's mental health with a 15 per cent increase in Medicare-subsidised mental health services between March and September.

The AMA called for a mental health specialist to assist government and welcomed the appointment of Dr Ruth Vine as Australia's first Deputy Chief Medical Officer for Mental Health in May.

By June a second wave of the virus hit Victoria and inadequate PPE and training for its use emerged as a key failure. Thousands of Victorian doctors, nurses and health care workers contracted the virus.

AMA demanded health care workers treating known or likely COVID-19 patients be provided with P2 or N95 particulate filter respirator masks, rather than standard surgical masks.

The AMA relentlessly called out these failures and successfully lobbied the Infection Control Expert Group to update national guidelines.

In July, the AMA signed Amnesty International's pledge for the protection of global health and essential workers on the frontline of COVID-19. AMA acknowledged Amnesty's report, *Exposed, Silenced, Attacked: Failures to Protect Health and Essential Workers During the COVID-19 Pandemic*, highlighting the thousands of health workers known to have died from COVID-19 worldwide.

Following six months of restrictions and lockdowns, family separations and financial setbacks, the AMA Federal Council issued a special communique in September calling on all governments not to squander these sacrifices. It set the direction for forthcoming advocacy and reinforced ongoing vigilance and social distancing to minimise lockdown in the inevitable event of further outbreaks, due to breaches of quarantine.

The AMA's predictions were sadly proven correct, outbreaks in South Australia, New South Wales, Victoria and Queensland garnered very different responses from the various state governments.

The AMA advocated for mask wearing in public places and where social distancing was not possible and national consistency in the response to outbreaks – a goal that remained elusive.

COVID-19 exposed the massive failings in our aged care system.

The AMA continued to advocate for action to reform the obvious flaws in the care of our most vulnerable citizens calling for mandated minimum staff-to-resident ratios with a mandated skill mix, a 24/7 registered nurse presence in nursing homes and adequate access to PPE, training in infection control, and review of infection control procedures.

Aged care advocacy also centred around national paid pandemic leave arrangements, increased funding for home care packages and more transparency and accountability in how aged care providers spend Government funding.

The AMA's advocacy was instrumental to the Government's establishment of a new National COVID-19 Evidence Taskforce, national surveillance of healthcare worker COVID-19 infections, and a new national network of epidemiologists.

Dr Omar Korshid appeared before the Senate Select Committee inquiry into COVID-19 giving evidence on the impacts of COVID-19 on healthcare workers and commenting on Australia's vaccine roll-out.

He was also invited onto the Australian Commission on Safety and Quality in Health Care (ACSQHC) National Clinical Taskforce, representing the medical profession in ensuring that healthcare workers are protected from infection.

With an eye on the future promise of a coronavirus vaccine in 2021, the AMA started lobbying as early as August, for a Therapeutic Goods Administration (TGA)-endorsed vaccine to be distributed to at-risk groups first, prioritising the aged and those with other health conditions increasing their vulnerability.

Generally supportive of the Government's approach to procuring vaccines, the AMA had continuous discussions with the TGA, the Department of Health and Health Minister Greg Hunt about supply chains, safety, efficacy, and the critical role of general practice in rolling out vaccines to the wider community.

Extensive lobbying secured places for GPs on two Australian Technical Advisory Group on Immunisation (ATAGI) working groups ensuring the AMA's insight into vaccine development and the rollout of the biggest mass vaccination in a century.

With the economic impacts of the pandemic biting, National Cabinet released a draft 'Framework for Reopening' in October. The AMA denounced the significant change in direction with governments now emphasising the economy over health.

As the year drew to a close, December marked the first full year since the emergence of the virus with 1,832,640 deaths worldwide*. The United Kingdom approved the Pfizer BioNTech vaccine under emergency conditions to begin vaccinating its population.

The AMA underscored Australia's privileged position to be able to observe and learn from the UK experience. As Australians went into the Christmas season the AMA issued a holiday warning emphasising hygiene practices, social distancing, mask wearing, tracking movements and celebrating outdoors where possible.

The COVID-19 response is set to continue uppermost in the AMA's advocacy approach into 2021.

* Source: Worldometer - www.worldometers.info. We worked with the Government to support future funding for private hospitals to ensure sustainability of the private hospital sectors... considerable effort out of pocket.. e Commonwealth Private Hospital guarantee.

ADVOCACY HIGHLIGHTS

2020 was an extremely busy year of advocacy in addition to the COVID-19 response. Here are some of the highlights.

TELEHEALTH

Australia's success in managing COVID-19 began with telehealth. Overnight, Australia's doctors changed fundamentally the way in which they provide care for their patients. At a time when we still had little idea of the threat that we faced, doctors arranged their practices to ensure their patients were able to receive the care they needed. This wasn't easy and it wasn't seamless – the AMA had to fight hard to get telehealth extended to all specialties and to protect all Australians.

It began with the AMA raising concerns to the Government that GPs were likely to be one of the first places a person with COVID-19 will turn up. The lack of PPE in part due to the still ongoing bushfires, and partly due to global shortage, meant that GPs were exposed. The Government listened and brought in initially limited MBS telehealth items. By the end of March, the AMA was able to get this expanded to all Australians.

Over the following months, the AMA worked closely with the Government and the Department of Health to refine telehealth. Our members provided extensive feedback on how it was working and where it was not which we passed on to the Department. It is thanks to this member feedback that we were able to turn the rapidly developed system into the telehealth we still have today.

Telehealth had been a major priority for the AMA for years. We knew the potential that telehealth had to improve the health system and the outcomes for our patients. It has existed for some specialties and in some areas in the past, but it was patchwork. Australians were missing out, meanwhile Australia's doctors were regularly providing forms of telehealth with no reimbursement.

By continuing to provide effective and safe care over the telephone or by videoconference, Australia's doctors have shown that telehealth is a valuable addition to healthcare. The AMA will continue to advocate for a model that ensures continuity of care with a patient's regular doctor and is manageable for patients and practices.

PRIVATE HEALTH

Australia's health system relies on the dual system of public and private health. The two complement each other. But private health insurance is in trouble, placing the whole private sector at risk.

Private health insurance is very complex, and doctors have a complicated relationship with it.

The AMA has been working on understanding the economics behind the state of private health insurance and is not content to let the private health insurers be the only voice heard by Government.

Throughout 2020, the AMA worked to ensure the voice of medical practitioners was front and centre in this debate and in August released the *AMA Prescription for Private Health Insurance*.

AMA analysis revealed the existing policy settings used by Government were outdated and no longer had the desired effect. This stemmed from changes in the cost of premiums, Medicare and health fund rebates falling behind the cost of providing services, and young Australians earning relatively less than older generations.

The report outlined the necessary changes required to the premium rebate, lifetime health cover loadings, Medicare surcharge levy, and youth discounts to improve the affordability for younger Australians and those on lower incomes, while also incentivising people to maintain their insurance in the longer term.

Further policy reforms are recommended to the design of private health insurance policies, such as a minimum level of benefits being provided to improve transparency for consumers and demonstrate the value for patients.

The Federal Health Budget released in October 2020, demonstrated the Government listened to the AMA. Numbers of its recommendations were picked up by Government and included in the budget and hopefully more will follow.

The AMA understands that one report will not fix the decline of the private health system in Australia and will continue to work to ensure its viability and sustainability into the future. Also see page 25.

AGED CARE REFORMS

COVID-19 had a devastating impact on aged care throughout 2020, and in responding the AMA emerged as one of the strongest voices advocating for workers and residents in the aged care sector.

After receiving reports on nursing homes' preparedness from members at the start of the pandemic, the AMA reached out to the Department of Health and the Aged Care Quality and Safety Commission, calling for a number of actions to ensure safety of aged care residents, including:

- Lowering the threshold for COVID-19 testing to when a single person in a nursing home shows symptoms and testing asymptomatic residents and staff when a single positive case is detected.
- Consistent national rules for testing of nursing home residents.
- Improved guidance around the rules for cohorting of residents including further clarification to allow operators to have designated COVID-19 homes, where COVID-19 infected patients are cared for by dedicated COVID-19 staff.
- Improved guidelines around palliative care in nursing homes.
- Improved guidelines around specialist appointments for residents.
- Addressing workforce issues in rural and remote areas.

The AMA also advocated strongly for the compulsory use of face masks in all nursing homes, nationwide, not just in COVID-19 hotspots, a position subsequently adopted by the Federal Government.

The benefits of the breakthrough agreement the AMA reached with the Government on telehealth were felt in aged care, allowing continuity of care between aged care residents and their GPs while reducing the risk of infection and conserving scarce PPE.

In September, the AMA provided a comprehensive submission to the Royal Commission into Aged Care Quality and Safety's inquiry into the impact of COVID-19 on aged care services.

The AMA's call for the expansion of the *Better Access* to mental health Initiative to nursing home residents was accepted by the Royal Commission and subsequently by the Department of Health. The AMA worked with the Department on the development and rollout of the new GP mental health items in aged care.

Following multiple COVID-19 outbreaks in nursing homes in Victoria, AMA Victoria was instrumental in the establishment of the Victorian Aged Care Response Centre, while robust Federal AMA advocacy led to the subsequent Government decision to replicate aged care response centres in other jurisdictions.

The AMA also called for urgent, coordinated federal/state/territory proactive risk assessment and a robust plan for nursing homes Australia-wide. Key to this was their ability to safely cohort infected residents and the capacity to provide supportive treatment to the residents within the home. This position was subsequently accepted by the Federal Government, with the Prime Minister and the Acting Chief Medical Officer acknowledging and agreeing with the AMA approach. Also see page 27.

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

It is widely known that when Aboriginal and Torres Strait Islander people develop solutions to meet the health needs of their local communities, better outcomes are achieved. This was certainly the case during the height of the COVID-19 pandemic when Aboriginal and Torres Strait Islander leaders and organisations successfully mitigated the impact of COVID-19 on country through culturally informed strategies.

Whilst the COVID-19 pandemic exposed the health gaps between Aboriginal and Torres Strait Islander people and their non-Indigenous peers, it also demonstrated the resilience, innovation and determination of First Nations Peoples and organisations to lead responses to protect their communities from deadly disease.

Aboriginal Community Controlled Health Organisations (ACCHOs) have been at the forefront of innovative primary health care for decades, and throughout this pandemic, have led the decision making and cultural protocols using technology to reduce the risk of COVID-19 in communities.

Culturally appropriate, tailored public health messaging was developed, such as the *Keep our Mob Safe, Stop the Spread* campaign and communicated through community networks.

In addition, access to services was increased through the establishment of more clinics and point of care COVID-19 testing, organised deliveries of food, medicines, and other essential supplies, as well as doctor visits - all done with existing resources and on top of usual service delivery.

As a result of the efforts of ACCHOs, the rates of COVID-19 among Aboriginal and Torres Strait Islander people in Australia remain proportionately lower than the rest of the population. This success reflects the critical importance of Aboriginal and Torres Strait Islander leadership in responding to health needs in communities and demonstrates that culturally informed solutions can affect real change.

Throughout the COVID-19 pandemic, the AMA called for governments to prioritise the health needs of Aboriginal and Torres Strait Islander people in national measures being introduced to control COVID-19. This was to recognise the greater susceptibility to COVID-19 resulting from higher rates of underlying chronic diseases, overcrowded living conditions, and other health-related factors in Aboriginal and Torres Strait Islander people.

The AMA will continue to work closely with key First Nations health organisations to support their work. We commend the ACCHO sector for its leadership, prompt responses and innovation to protect First Nations communities from COVID-19.

While this has no doubt been a successful outcome, we will remain vigilant for as long as COVID-19 exists within the broader community. Also see page 32.

PREGNANCY WARNING LABELLING

2020 marked the success of the AMA's decade-long advocacy efforts to make pregnancy warning labels mandatory on alcoholic beverages.

The AMA first made the call in its 2012 *Alcohol Position Statement* as strong evidence emerged linking Fetal Alcohol Spectrum Disorder (FASD) with alcohol consumption during pregnancy.

Many Australians are still unaware of the dangers of drinking alcohol while pregnant, and at least 35 per cent of Australian women continue to drink while pregnant.

People born with FASD may suffer from a range of neurocognitive impairments and are more likely to have educational difficulties and ultimately connect with the criminal justice system.

Food Ministers from each Australian state and territory voted to mandate labels in 2018 and engaged in a lengthy consultation to develop a standard label. Along with other public groups, the AMA called for a black, white and red label of sufficient size and placement to be noticeable by consumers.

Just ahead of the final decision on the label, the alcohol industry ramped up significant pressure on ministers via closed-door lobbying and public messaging, arguing that a clearly noticeable label would be prohibitively expensive to implement.

Their cheaper proposal diminished the impact of the label with no mandated colour contrast requirements. Mock-ups comparing the two showed the black, red and white label to be far more noticeable - a vital element of a warning label.

With ministers leaning towards the watered-down label, the AMA joined an advocacy coalition led by the Foundation for Alcohol Research and Education to champion the clear label for public health.

Campaigning took the form of giving voice to people with lived experience of FASD, an open letter appearing in newspapers across Australia, and tireless work by state and territory AMA representatives influencing their relevant ministers.

In July, the ministerial forum voted by a slim margin in favour of the red, white and black label. Alcohol manufacturers have three years to introduce the label.

This significant victory in the face of heavy industry pressure, demonstrated the effectiveness of concerted, evidence-based advocacy on public health grounds.

VAPING

Nicotine harm and vaping was a significant focus in 2020. The AMA's position stands strong: the best way to reduce harm from vaping, e-cigarettes and tobacco is to reduce access to these products, especially for younger Australians. They should be strictly regulated and funding for proven reduction strategies should be increased.

The available evidence does not support nicotine-vaping products as effective smoking cessation aids and finds vaping can lead to non-smokers taking up tobacco smoking. Studies also show people using vaping as a quit aid are significantly more likely to still be vaping after a year than people using nicotine patches or other therapies.

A consultation by the TGA provided an avenue for the AMA to further advocate its position and resulted in extensive collaboration between the AMA and the TGA.

The TGA classifies medicines and poisons into 'schedules' which determine their availability to the public and level of regulatory control. After a long consultation process, the TGA made a final decision in December to make nicotine vaping products prescription only. This decision closes a loophole in the current system, whereby Australians can easily access nicotine-containing vaping products without a prescription by purchasing them from overseas. This is despite their being illegal to sell Australia-wide and illegal to possess in all jurisdictions except South Australia.

The AMA was a strong advocate for this change, in submissions to both the TGA and a related Senate Inquiry. AMA President Dr Khorshid made a number of powerful public statements on the lack of evidence that vaping is effective at helping people to quit tobacco smoking, the alarming uptake of vaping products among young Australians, and the health risks associated with their use.

The TGA has a long road to travel before the changes are implemented on 1 October 2021. It must ensure there is adequate communication to prescribers to prepare them for the change, create nicotine-vaping product standards, and update prescribing guidelines to ensure adequate, evidence-based steps are taken before a nicotine e-cigarette is used as a last-resort measure for smoking cessation.

This will be a considerable challenge for the TGA, as guidance will need to balance the lack of evidence for nicotine vaping as a smoking cessation method with providing enough information on the new prescribing process available to doctors.

The AMA predicts an influx of patients visiting their GP for a prescription. This is why the AMA will be working closely with the TGA throughout 2021 so the above guidelines, standards, and communications are suitable and wide-reaching to ensure all doctors are ready for the change.

AMA ADVOCACY

The AMA has advanced many other issues in 2020 on behalf of AMA members

MEDICAL PRACTICE

Fees List

The AMA Fees List continues to be a popular and valuable benefit for members, providing guidance for doctors setting their medical fees. The Fees List was extensively updated in 2020 following significant changes in the Medicare Benefits Schedule (MBS) Review from 2015. Among the changes are:

- Emergency medicine - 36 new and 11 deleted items
- Intensive care - 6 new, 2 deleted and 5 amended items
- Diagnostic Imaging – Over 400 item changes
- Pathology - 32 new items
- Cardiac - 35 new and 18 deleted items
- Diagnostic sleep services – 14 amended items
- Urology - 20 new items, 96 amended items, and 13 deleted items
- Neurology and neurosurgery - 16 new items, 42 deleted and 37 amended items
- Blood product services - 1 new, 1 deleted and 2 amended items and
- Chemotherapy services - 1 new, 12 deleted and 1 amended items.

As the MBS Review recommendations are implemented in the remaining specialty areas, the Fees List will continue to evolve.

MBS Review

As a result of AMA advocacy relating to the implementation of the MBS Review recommendations, the Department of Health now conducts information sessions for insurers, clinicians, billing agencies and others who are affected by MBS changes. We continue to push for further improvements including longer lead time for changes, better consultation processes and more information for the sector.

Cardiac, spinal surgery and computed tomography angiography services

The AMA organised a coalition of peak bodies who called on Minister Hunt to review the cardiac diagnostic service changes from 1 August, that impacted general practice, including Electrocardiogram.

The AMA's response to the MBS Review of Spinal Surgery again raised the issues of poor implementation.

The AMA responded to a Departmental consultation on proposed changes to Computed Tomography Angiography (CTA) correcting an anomaly enabling GPs to request the CTA service for exclusion of pulmonary embolism.

Medical Indemnity

July 2020 saw the culmination of years of advocacy from the AMA with the implementation of the Commonwealth Government's medical indemnity reforms. The AMA was successful in protecting the Commonwealth's investment in medical indemnity insurance ensuring the reforms did not become a cost cutting measure that would dramatically increase insurance premiums for members. Working with the major medical indemnity insurers, the AMA was able to ensure legislation, regulation and implementation did not adversely impact the profession.

Private Health Insurance

The AMA continued its private health insurance advocacy with the release of the *AMA Prescription for Private Health insurance* in August. This detailed policy blueprint for private health insurance calls on Government to revisit many of the existing policy levers and introduce some new ones. These reforms are needed to slow the decline of the insured population today, and this document provides detailed analysis for Government to make these important changes.

The Government heeded the AMA's call for private health insurers to allow people aged under 30 continued cover under their parents' policies. This was announced in the Commonwealth Budget. The Government also announced funding for further analysis of the of the key policy settings for private health insurance in Australia, which the AMA had been pushing for. Also see page 18.

AMA Private Health Insurance Report Card 2020

The report card was released in September and provided much-needed clear, simple information about how health insurance really works, aiming to instil more confidence in the private health insurance system.

Our 2019 report card detailed the impact of private health insurance reforms. Revisiting these reforms in the 2020 report card, we showed they have not reversed the decline in private health insurance or changed the underlying numbers which are threatening the stability of our private health system.

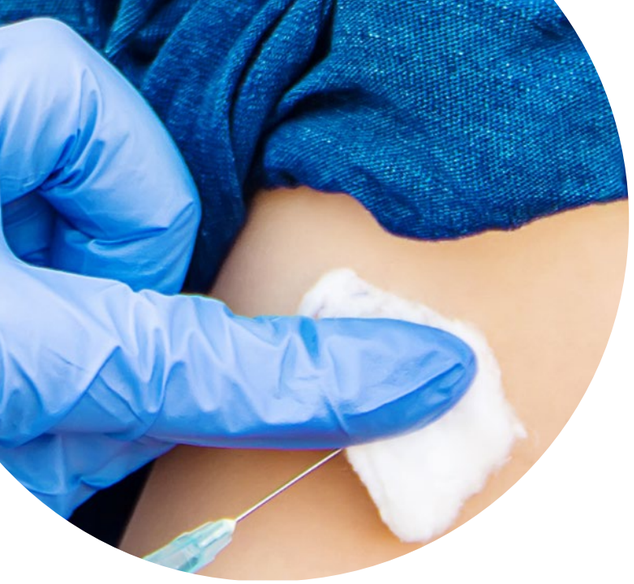
National Registration and Accreditation Scheme

More than six years of AMA advocacy with the Medical Board of Australia (MBA) and the Australian Health Practitioner Regulation Agency (AHPRA), culminated in the release, in December, of a vexatious complaints framework by AHPRA. This framework should help identify, manage and reduce the impact of vexatious complaints.

Informed Financial Consent

The AMA continued work to increase patient health literacy by updating its 2019 guide to informed financial consent. This document supports patients to create a dialogue that will improve transparency about treatment options, charges and expected out-of-pocket costs.

The document was re-released in September with a total of 28 key medical organisations joining the collaboration as a result of the AMA's lead.



Scope of Practice

The AMA's continued vigilance over patient safety tackled non-medical health professionals expanding the scope of practice beyond their training and expertise in areas including pharmacy attempts at prescribing, nurse practitioners and in the medical radiation space.

Medicare Compliance

The AMA advocated for improved compliance education consisting of:

- real education without unwarranted threat of punishment and unnecessary obligations to audit own records;
- consistent and accurate advice by Ask MBS linked to policy intent of items and well-trained staff;
- MBS changes and Review implementation to be communicated directly from the Department to affected medical practitioners; and
- coordinated compliance education between all related areas of the Department.

The AMA is also engaged with the Department of Health to ensure the draft *National Health (Data-matching) Principles 2020* are transparent, matched data is fully deidentified by the use of assigned pin numbers or temporary random individual identifiers, and clinicians affected by compliance actions are offered clearly documented procedural fairness processes.

The AMA successfully secured a review from the Minister of Health of the Section 92 agreements process of the Professional Services Review scheme.

Therapeutics

The TGA adopted the position argued in AMA submissions opposing the down-scheduling of medication such as sildenafil (Viagra), ondansetron, and nicotine, to increase access to heated tobacco products.

The AMA will continue to monitor and respond to medicine scheduling proposals to ensure the level of medicines access is safe for patients.

The AMA worked with representatives on the TGA Medicine Shortages Working Party on monitoring, communicating, and managing medicine shortages during and beyond the pandemic.

The TGA has reflected AMA policy by continuing to prohibit self-testing in-vitro diagnostic medical devices (IVDs) for genetic testing and for cancer. The TGA also reflected the AMA's stance that several risks must be mitigated before lifting the prohibition on other self-testing IVD's.

Digital health system efficiencies

After extensive AMA advocacy, the Government made essential changes to the interim arrangements for ePrescribing streamlining sate/territory and federal inconsistencies such as the unnecessary requirement for a paper prescription to be sent to pharmacies within 15 days of a medicine being supplied.

AMA continued advocacy for improvements to the My Health Record for clinicians ensuring interoperability with clinical systems used by health providers. Representatives are working with government departments and agencies on the statutory review of the My Health Record legislation to ensure any legislative changes improve utility of the My Health Record.

An AMA member chairs a committee that will develop a specialist digital health toolkit to lower the administrative barriers to specialists' adoption of eHealth tools. Modules include clear advice on the uptake of the My Health Record in specialist practice, ePrescribing, secure messaging, and clear advice for specialists on their obligations for the privacy and security of patient data and when data breaches must be reported.

PUBLIC HOSPITAL DOCTORS

The AMA Council of Public Hospital Doctors contributed to the AMA's Public Hospital Report Card. Public hospitals came under particular pressure over the last year, especially in Victoria, as parts of the nation saw an increase in COVID-19 patients. The Council of Public Hospital Doctors was a leading voice in seeking to address COVID-19 impacts for public hospital staff and patients, particularly through advocacy on access to appropriate PPE.

The 2020 Public Hospital Report Card demonstrated yet another year of declining patient access to public hospital treatment within clinically recommended timeframes, a stagnant rate of elective surgery when total admissions grow year on year, too few public hospital beds and a Commonwealth indexation formula that bakes in under-funding. These statistics counter the Government's anticipated claim of highest ever public hospital funding.

AGED CARE

Aged care remains one of the key AMA advocacy priorities. The AMA provided seven submissions to the Royal Commission into Aged Care Quality and Safety and the AMA President appeared before the Royal Commission three times.

Several AMA recommendations to improve the aged care system were supported by the Counsel Assisting Royal Commission, including mandatory minimum staff-to-resident ratios, availability of registered nurses 24/7 in aged care facilities, and minimum mandatory qualifications for aged care staff.

The AMA participated in other Government aged care consultations supporting the establishment of a National Worker Registration Scheme in aged care that would encompass minimum qualifications for aged care workers, worker screening, code of conduct for aged care workers, minimum English language requirement, continuous professional development and recognition of previous work experience for aged care workers.

The AMA is a member of the working group established in 2020 by the Australian Digital Health Agency, tasked with implementing My Health Record in nursing homes, as well as integration of My Health Record and My Aged Care. We worked to significantly improve communication between all stakeholders involved in care of older people who are often

transferred between multiple care providers and will contribute to optimising their care.

In 2020 the AMA successfully advocated towards stopping the privatisation of Aged Care Assessment Team services planned by the Federal Government. The plan would have seen aged care assessment services taken out of the public hospital system, removing essential input from geriatricians, and outsourced to private providers. The proposed tender-based approach had the potential to further fragment the care for older people, leading to increased and prolonged hospital stays for many of them.

The AMA's new position on *Palliative Care in the Aged Care Setting* details palliative aspects of medical care for older people, focusing on the palliative care service provision in both older people's home and after they enter nursing homes. It summarises the role of medical practitioners in palliative care, the role of aged care providers, and palliative care planning and training required to implement palliative care in the aged care setting. The position was subsequently accepted by the Federal Government, with the Prime Minister and the Acting Chief Medical Officer acknowledging and agreeing with the AMA approach.

The *2020 Medical Care for Older People* position statement outlines what high quality medical care for all older people should entail. It says the level of access to medical care should not change when an older person changes where they live and nor should access to medical services be adversely affected by entry to a nursing home. Also see page 19.

GENERAL PRACTICE

Telehealth

The COVID-19 pandemic significantly impacted general practice and this was recognised early by the government.

The AMA played a significant role in brokering a breakthrough $669 million agreement with the Federal Government to expand telehealth access to general practitioners and other medical specialists under Medicare that allowed for continuation of normal patient care and reduced the need for scarce PPE.

After years of AMA advocacy, Medicare-funded telehealth item numbers were made available on a temporary basis, and gradually tweaked to make them more fit-for-purpose.

Funding support for General Practices during COVID-19

The AMA supported JobKeeper and other initiatives to help GPs with the economic challenges of COVID-19. When mandatory bulk billing was an early issue, AMA advocacy ensured GPs and Other Medical Practitioners were supported. AMA won a temporary doubling of the bulk billing incentive and Practice Incentive Program Quality Improvement Incentive payments under the Practice Incentive Program.

Continuity of Care

The AMA has long supported patients having a usual GP and a medical home in their usual general practice. Funding must also support longitudinal and comprehensive care. AMA advocacy led to the Government committing to introduce a voluntary nomination scheme for patients - initially patients over 70 and indigenous patients over 50 years. AMA is working to ensure funding commitments to general practice are retained and that voluntary patient nomination supports blended funding and access to high value services.

Primary Care Reform

The AMA's *Delivering Better Care for Patients: The AMA 10-Year Framework for Primary Care Reform* highlighted the central role of general practice in health care. It identified immediate funding goals to ease the financial pressures on GPs, and long-term reforms that must be implemented as part of the Federal Government's 10-year Primary Health Care Plan.

We successfully advocated for reforms to remove the requirement for GP CPD to be reported via the GP Colleges, and to allow GPs to access to A1 rebates directly linked to their specialty recognition with the MBA.

The Government has maintained its commitment to a voluntary patient registration scheme, which will underpin blended funding mechanisms to better support general practices in delivery of value-based, longitudinal and comprehensive care.

We've seen improvements to incentives to support doctors working in rural areas and general practices, but there is much more work to do. Ensuring the general practice workforce into the future is a high priority for the AMA and we are exploring how our GPs in Training can be supported through potential reform in their employment arrangements.

Workforce Incentive Program

January 2020 saw the introduction of the Workforce Incentive Program (WIP) as a result of AMA advocacy. It provides better support for doctors working in rural areas and support for practices to employ pharmacists along with practice nurses and other allied health providers to build GP-led, multidisciplinary teams.

Workforce, distribution, and training

The AMA continues to represent the profession in discussions with government around GP workforce planning and distribution. We have led calls for changes to the model of employment for GP registrars to make GP training more attractive to junior doctors. Similarly, the AMA has been engaged in upcoming changes to GP training, including the transition of training back to the Colleges.

Practice Incentive Program (PIP) Quality Improvement Incentive (QII)

AMA advocacy led to additional funding announced in the 2019-20 Budget for the PIPQII. This additional funding will better support quality improvement in general practice to ensure practices are not left worse off as a result of its implementation.

AMA advocacy also ensured greater flexibility for participating practices in extracting and submitting the PIP Eligible Data Set. Practices were also given additional time to submit their first quarter data. A model data sharing agreement was also developed as a reference document for Primary Health Networks and general practices. Patient privacy has been a paramount concern for the AMA throughout the development of the PIPQII and AMA advocacy has contributed to further strengthened PIPQII data privacy and security.

Wound care

AMA efforts to see GPs better supported in providing wound care resulted in the establishment of a wound-management trial to run from 1 December 2019 to 30 June 2022 to test models of care for chronic wound management.

The MBS Review Taskforce implemented a Wound Management Working Group (WMWG) to which the AMA has contributed two submissions. The final recommendations from MBS Review Taskforce are now with Government.

Rural Doctors

The AMA Council of Rural Doctors (CRD), under Dr Marco Giuseppin, has continued to raise concerns with the Government about barriers to private sector relocation to regional Australia, and the future of regional training organisations. CRD is actively working with other key stakeholders to develop infrastructure to support more rural training for GP and non-GP specialists, and has provided extensive feedback on the review of the Rural Health Multidisciplinary Training Program.

The AMA is acutely aware of the need to keep COVID-19 out of our rural and remote communities, where local health services would be quickly overwhelmed, and this has been at the forefront of our advocacy to all levels of Government.

Rural Procedural Grants Program

AMA advocacy ensured continued funding of the Rural Procedural Grants Program (RPGP) including its expansion to support emergency mental health training.

Bonded medical placements

Both the Bonded Medical Places and Medical Rural Bonded Scholarship programs have been radically overhauled, giving participants who take up the new arrangements much more flexibility in where they can work and fairer return of service arrangements.

National Rural Generalist Pathway

Following AMA advocacy, additional funding was secured to fast track the National Rural Generalist Pathway program.

DOCTORS IN TRAINING

The AMA Council of Doctors in Training (CDT), led by Dr Hash Abdeen, has continued its excellent work advocating for the welfare and training of our junior doctor workforce.

CDT focused during 2020 on the unique needs of trainee doctors adversely impacted by COVID-19 restrictions. Interruption to fellowship exam preparation was a key focus, particularly the challenging transition to online exam formats. The CDT additionally worked on support for trainee doctor parents, and the mental health and wellbeing of junior doctors as demonstrated by the CDT's leadership in the launch of the national wellbeing initiative *Every Doctor, Every Setting: A National Framework.*

Also acutely aware of the other challenges facing our doctors in training, AMA met with the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine to discuss exam failures, and how to best support trainees through the trauma of the abandoned exams.

CDT worked hard on issues affecting doctors in training during COVID-19 and produced several key resources to support doctors in training during the COVID-19 response. These have been well received by doctors in training members and the broader medical profession.

Doctors in training resources

- AMA advocacy to support doctors in training during the COVID-19 response.
- Communique: AMACDT online Trainee Forum - COVID-19 and its impact on specialty training.
- Communique: AMACDT online Trainee Forum - COVID-19 and its impact on exam processes.
- Communique: AMACDT online Trainee Forum - COVID-19 and contingency planning for online examinations.
- Medical College responses to COVID-19.
- Supporting General Practice registrars during the COVID-19 pandemic.
- Coronavirus (COVID-19) Medical Student Public Hospital Engagement Contract Offer Check List.
- Department of Health - AMACDT Webinar discussing COVID-19 and the impacts on Doctors in Training.

Workforce Briefings

- Delaying recruitment and the start of the 2021 clinical year in response to COVID-19. April 2020.
- COVID-19 impacts on the doctors in training workforce. July 2020.

Better employment arrangements for GP and other private practice trainees

COVID-19 accentuated the vulnerabilities associated with current employment arrangements for GP trainees and other private practice trainees. CDT hosted a Single Employer Model for GPs in Training Planning Day on 6 December 2020 to discuss how to improve employment conditions for GPs in training while supporting supervisors and practices to provide excellent training. The discussion informed the AMAs submission to the Department of Health on its preferred model for employment for GPs in Training.

Attendees agreed that the National Terms and Conditions for the Employment of Registrars (NTCER) had outlived its purpose. Any new employment model should deliver pay and conditions comparable to non-GPs in Training and should allow GPs in Training and supervisors to focus on the learning rather than being service delivery and business arrangements.

A trial of the single employer model for GP registrars that the AMA has been promoting commenced in the Murrumbidgee Local Health District.

Expanding accreditation and protections to prevocational/ unaccredited trainees

The pandemic has highlighted the deficits in the prevocational/unaccredited trainee space and the urgent need to expand accreditation and protections of this group. The AMA has called on the Government to show national leadership to commit to fund and resource the appropriate agencies to undertake the accreditation of all prevocational training positions to improve the quality of training and support for prevocational doctors not in a College training program. Further, the AMA has advocated that this be a key area for immediate action as part of the National Medical Workforce Strategy.

Specialist Trainee Experience Health Check

CDT released the first Specialist Trainee Experience Health Check report card on how the various Colleges are delivering training , identified areas for improvement based on the Medical Training Survey. It found a commitment at all levels of training is needed in areas including exam feedback, access to mental health services, addressing bullying, discrimination, and harassment, providing access to study leave, and supporting employment at the end of training.

National Framework to support coordinated action on the mental health of doctors and medical students

The AMA President was pleased to join representatives of Everymind, Australian Medical Students' Association, and other groups at the launch of *Every doctor, Every setting: A national framework* to support coordinated action on the mental health of doctors and medical students funded by Minister Greg Hunt in 2017. The timely release of the Framework in October aims to reinforce the health and wellbeing of doctors as a national priority. It follows the release of the revised AMA Position Statement on *Health and wellbeing of doctors and medical students – 2020*. We expect to implement this Framework in the coming year.

Member engagement in policy development

The CDT established Special Interest Groups and Advisory Committees to provide an avenue for wider member engagement by allowing any DiT member the opportunity to contribute to CDT advocacy and policy development at a Federal level.

PUBLIC HEALTH

Raising the Age of Criminal Responsibility

The AMA is a lead member of the Campaign team 'Raise the Age' which is lobbying Attorneys General to raise the age at which children can be imprisoned. In Australia, children as young as 10 can be sent to prison, even while awaiting mental health assessment and trial.

In 2020 the ACT government committed to raising the age of criminal responsibility from 10 to 14 years and will pursue this legislative reform in their new term of government.

Gun Safety

The AMA is part of a select advocacy group, including the Alannah & Madeline Foundation, Law Council of Australia, and Public Health Association, liaising with the Federal Government to ensure the National Firearms Agreement is adhered to and information about gun control measures is improved. The group met with Ministers and will join roundtable discussions with Border Force, Australian Federal Police and other law enforcement agencies. The Government remains committed to the National Firearms Agreement and AMA is working with them on public information messaging.

National Preventative Health Strategy

The AMA was invited by the Department of Health to be a member of the Expert Steering Committee for the National Preventive Health Strategy. Development of the Strategy progressed significantly with the AMA's policy positions and targets - including our call for five per cent of total health spending to be allocated to prevention by 2030 - strongly influencing the final draft.

Climate Change and Natural Disasters

The AMA's work to centre health impacts as part of the public discussion on climate change in 2020 saw a marked rise in public awareness of this issues, especially during the bushfire season. Our proposal for GPs to be involved in local, state, and federal disaster planning and responses was one of the recommendations of the final report of the Bushfire Royal Commission in October, as well as longer-term mental health supports following natural disasters. The AMA gained significant media attention for our endorsement of the Climate Change Bill proposed by independent MP Zali Steggall in November, as well as our joint role in launching the 2020 MJA-Lancet Countdown on Health and Climate Change in December.

Doctors for the Environment

Federal AMA President Dr Omar Khorshid committed the AMA to a new method of advocacy for climate health by entering a three-year Memorandum of Understanding with Doctors for the Environment. The agreement has seen the AMA and Doctors for the Environment undertake joint meetings with arms of governments and issue public statements on the link between climate change and adverse health outcomes.

Indigenous Australians' Health

As part of the Department of Health's Comprehensive Primary Health Care Sustainability Advisory Committee (CPHC SAC), AMA contributed to the development of a new Indigenous Australians' Health Program funding model, announced by Minister for Health in November 2019. It provides Aboriginal community-controlled health services (ACCHS) with $90 million over three years. Implemented on 1 July 2020, the funding will ensure ACCHSs continue to provide quality, comprehensive, and culturally safe primary health care over the next few years. The CPHC SAC will continue to monitor and review the funding model to ensure that it remains fit-for-purpose.

In December, the AMA President was privileged to present the 2020 AMA Indigenous Medical Scholarship to Lloyd Diggins, a third-year University of Notre Dame Australia medical student who plans to work as a GP in remote communities. Lloyd's acceptance speech was a blistering summation of the casual racism that still exists in our healthcare systems.

Australia is very lucky to have been able to keep COVID-19 out of our remote Indigenous communities, where its effects would be devastating. Our ACCHS have played an outstanding role in keeping these vulnerable communities safe, and we must support them to continue in these efforts.

The AMA's continued advocacy on Indigenous health supported our long-established commitment to the Closing the Gap targets which in 2020 saw the AMA support new targets to achieve better health outcomes for First Australians. Also see page 20.

Rheumatic Heart Disease (RHD) Endgame Strategy

The AMA is a founding member of the END RHD coalition and contributed to the development of the *RHD endgame strategy: the blueprint to eliminate rheumatic heart disease in Australia by 2031*. It was launched in October 2020 by Minister Hunt, Professor Jonathan Carapetis, head of the Telethon Kids Institute and Ms Pat Turner, CEO of the National Aboriginal Community Controlled Health Organisation.

The evidence-based strategy outlines the steps needed to eliminate RHD and to improve the quality of life for those already living with the disease. It further provides guidance for the Commonwealth Government to fulfil its commitment to eliminating RHD within the next decade.

ETHICS AND MEDICO-LEGAL

Medical Board of Australia's *Good Medical Practice: A code of conduct for doctors in Australia*

During the Medical Board's two-year review of its code of conduct for doctors, the AMA advocated strongly to ensure the standards of professional conduct set out by the Board were appropriate, clear, explicit and operational so doctors can meet the standards by which their professional conduct will be evaluated.

The Board responded positively to the AMA's ongoing and consistent advocacy with the now updated good medical practice code reflecting a range of recommendations outlined by the AMA and the wider profession.

Advertising and public endorsement

The AMA provided multiple submissions to the Australian Health Practitioner Regulation Agency's revised *Guidelines for Advertising Regulated Health Services* highlighting the unique challenges posed by advertising through social media platforms. The AMA consistently advocated that if the guidelines can be easily undermined by doctors or other health practitioners, or the guidelines are simply not relevant to changing advertising practices, then they are failing to protect the public.

While doctors may use advertising to promote medical and other health-related services, the AMA recognises that advertising has the potential to harm individuals and the wider community if not undertaken appropriately.

While ensuring consistency with the AHPRA guidelines, the AMA revised *Position Statement on Advertising and Public Endorsement 2020* provides more explicit guidance for doctors on achieving higher standards of ethical behaviour in relation to advertising and public endorsement.

The updated policy includes a new section on advertising via social media as well as a new section on pathologising common human conditions and experiences.

Religious Discrimination Bills

The AMA fought against provisions in the Commonwealth's first and second Exposure Draft Religious Discrimination Bills. They protect the right of doctors to conscientious objection with little regard for the potential negative and harmful impact on patients' access to medical care. Amendments were made between the first and second drafts in response to a range of AMA concerns. The AMA argued strongly that provisions in the second exposure draft continued to be inconsistent with professional standards of behaviour, reduced patient safeguards and derogated patients' rights to access health care. At the same time they potentially undermined the rights of some doctors by enabling employers to discriminate against them on religious belief. The AMA has raised awareness of the implications of these bills amongst other medical organisations and the wider medical profession. Many have provided their own submissions, advocating similar positions.

Genetic testing and genomics in medicine

New developments in genetic and genomic testing have the capacity to transform health care in Australia potentially providing more cost-effective treatments and improving patient outcomes. The updated *Position Statement on Genetic Testing and Genomics in Medicine 2020* advocates that these technologies should be increasingly incorporated into everyday health care. It outlines ways to improve access to genetic and genomic services throughout Australia.

In recognising the ethical, economic and social factors associated with genetic and genomic testing, the revised policy also addresses consent to genetic testing and the protection of personal genetic information, genetic discrimination, direct-to-consumer genetic tests, access to testing services, research, gene and genetic patents, genetic selection and genome editing.

Palliative Care and End of Life Care

The AMA provided a submission on the Australian Institute of Health and Welfare's draft National Palliative Care and End-of-Life Care Information Priorities consultation document, to help guide the development of palliative and end-of-life care information over the next 10 years. The AMA underlined the need for the information to include rural, regional, and remote areas as well as those from culturally and linguistically diverse backgrounds. The AMA argued for the use of existing resources such as My Health Record, My Aged Care and PBS medications restricted for palliative care use to better inform the information priorities.

Ethics Framework for Pandemics

The AMA provided a submission to the National Health & Medical Research Council's consultation draft; An Ethics Framework for Pandemics a new guide for developing ethically informed policy and decision making on health issues during COVID-19 and future pandemics. The AMA highlighted the importance of stakeholder consultation in the process and the need for transparent feedback to demonstrate respect for stakeholders and their viewpoints. This ensures consultation was genuine and not token or a symbolic gesture and enhances public trust and confidence in the decision-making process.

The AMA also emphasised the importance of involving health care professionals and the wider health care industry in messaging on relevant public health issues. We highlighted the critical need to recognise increased risks, burdens and costs faced by public health workers and other frontline service providers with appropriate compensation.

Gender Equity, Inclusion and Diversity

The AMA Equity Inclusion and Diversity Committee has over the last year monitored AMA member views on achievement of improved diversity outcomes within the medical profession and the AMA organisation. The first Member Diversity Survey was conducted in December and revealed some progress has been made, but much more needs to be done.

The survey results will inform the AMA's future work on diversity, contribute to the AMA's wider goal of promoting a culture of inclusion within the medical profession and is a key action arising from the *AMA Diversity and Inclusion Plan 2020-2022*.

The Committee commenced involvement with the Monash University study on Advancing Women in Leadership to help progress work on diversity within both the AMA membership and the wider medical profession.

The AMA Diversity Report – Gender – 2019 was released and presents data on the gender make-up of the AMA Federal Board, councils and committees as at 31 December 2019, gender representation at AMA National Conference in 2019, and gender data for state and territory AMA boards and councils in 2019.

The gender target that all AMA councils and committees be comprised of 40 per cent women, 40 per cent men, 20 per cent flexible, was not met in 2019. However, the 2019 gender representation on AMA Federal Councils and Committees was slightly improved compared to 2018.

THE AMA AT WORK

Leading Australia's Doctors – Promoting Australia's Health

AMA COUNCILS, COMMITTEES & WORKING GROUPS

Councils

- Council of General Practice
- Council of Doctors in Training
- Council of Rural Doctors
- Council of Public Hospital Doctors
- Council of Private Specialist Medical Practice

Committees & Taskforce until 31 July 2020

- Ethics & Medico Legal Committee
- Health, Financing & Economics Committee
- Medical Practice Committee
- Public Health Committee
- Taskforce on Indigenous Health
- Equity, Inclusion and Diversity Committee
- Fees List Committee

Committees & Taskforce from 1 August 2020

- Ethics and Medico Legal Committee
- Public Health Committee
- The Taskforce on Indigenous Health
- Funding and Health System Reform Committee
- Mental Health Committee
- Psychiatrist Working Group
- Medical Practice Committee
- Equity Inclusion and Diversity Committee
- Fees List Committee

SUBMISSIONS

The AMA made submissions to the following:

- Data availability and Transparency Bill 2020
- Privacy Act Review
- Department of Health consultation on aspirations for the food regulatory system
- Draft National Medical Workforce Strategy
- Opportunities for reform of GP training employment arrangements
- Department of Health – National bowel cancer screening program review
- Evaluation of the DVA's allied health treatment cycle arrangements
- Department of Health review of the MBS heart health assessment items
- •NHMRC draft revised Australian guidelines to reduce health risks from drinking alcohol
- Feedback on draft National safety and quality primary healthcare standards
- Senate Select Committee on Tobacco harm reduction's Inquiry into tobacco reduction strategies
- Review of Food Standards Australia New Zealand Act 1991
- Review of assessing fitness to drive guidelines
- Aged Care Royal Commission in response to Counsel Assisting's recommendations
- Aged Care Royal Commission on the impact of COVID-19 on aged care services
- Aged care worker regulation scheme consultation
- Aged care legislation amendment (financial transparency) Bill 2020
- Proposed amendment to the Australian Immunisation Register Act 2015
- Therapeutic Goods Administration – interim decision on amendments to the Poison Standards – nicotine
- 2021-22 Public Hospital Pricing Framework
- Baseline report on quality use of medicines and medicines safety – phase one
- Therapeutic Goods Administration – proposed amendments to the Poisons Standard – interim decision on cannabidiol
- Therapeutic Goods Administration – proposed amendments to the Poisons Standard – November 2020
- NPS MedicineWise – Prescribing competencies framework review
- Therapeutic Goods Administration – scope of regulated soft-ware based products
- Select Committee on Autism
- Amendments to the GP Training draft outcomes framework
- Review of the national framework for medical internship
- Migration Amendment Bill 2020 (Prohibiting items in immigration facilities)
- Senate Select Committee on financial technology and regulatory technology
- Senate Finance and Public Administration Reference Committees Inquiry into lessons to be learned in relation to the Australian bushfire season 2019-20
- Senate Select Committee on COVID-19
- Activities of Jurisdictional coordination units supporting the national rural generalist pathways
- National Environment Protection Council's consultation on the proposed variation to the National Environment Protection (Ambient air quality) Measure Standards for ozone, nitrogen dioxide and sulfur dioxide
- Therapeutic Goods Administration – proposed amendments to the Poisons Standard - June
- General Practice Training Draft outcomes framework
- Pre-budget submission
- Supplementary submission to MBS Review wound management working group
- Therapeutic Goods Administration – proposed amendments to the Poison Standard – March 2020
- Council of Attorneys-General – Age of criminal responsibility working group review
- Second exposure draft of the Religious Discrimination Bill 2019
- Medical Board of Australia – draft guidelines for registered medical practitioners – complementary and unconventional medicine and emerging treatments
- Royal Commission into Aged Care Quality and Safety in response to the consultation paper 1 – aged care program redesign: services for the future
- Pharmaceutical Society of Australia – changes to antibiotic labelling and guidance by pharmacists
- Australian Commission on Safety and Quality in Healthcare – National dispensed medicine labelling standards

POSITION STATEMENTS

- Social determinants of health – 2020
- 2020 AMA vision statement for General Practice 2020
- Palliative care in the aged care setting 2020
- Medical care for older people 2020
- Health and wellbeing of doctors and medical students 2020
- Local hospital networks and GP-led primary care services designed to reduce potentially preventable hospitalisations 2020
- Rural training pathways for specialists 2020
- Genetic testing and genomics in medicine 2020

REPORT CARDS

- AMA Public Hospital Report Card
- AMA Private Health Insurance Report Card

APPEARANCES AND FORUMS

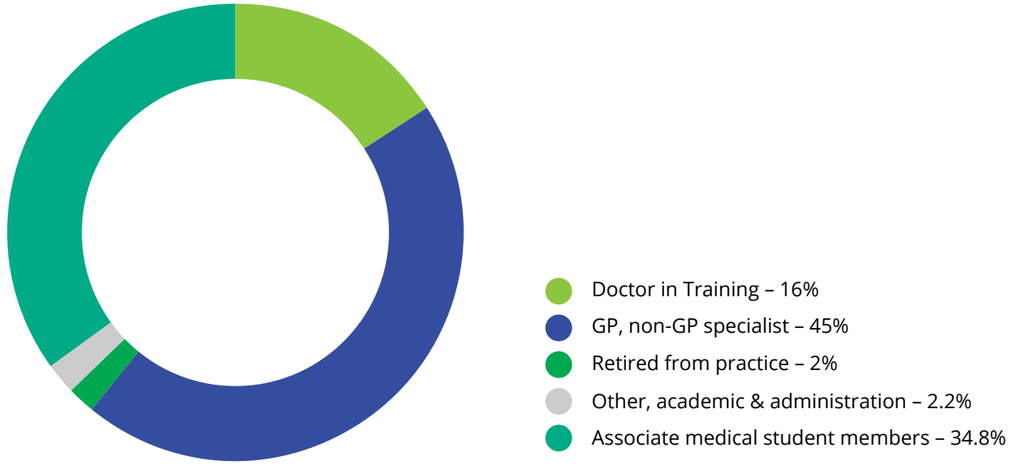
- Dementia Roundtable – Primary Health Care 10 Year Plan
- Older Australians Roundtable – Primary Health Care 10 Year Plan
- Clinical Governance in Aged Care Conference
- Strengthening the Aged Care Workforce Digital Summit – The Impact of COVID-19

REPRESENTATION ON COMMITTEES AND WORKING GROUPS

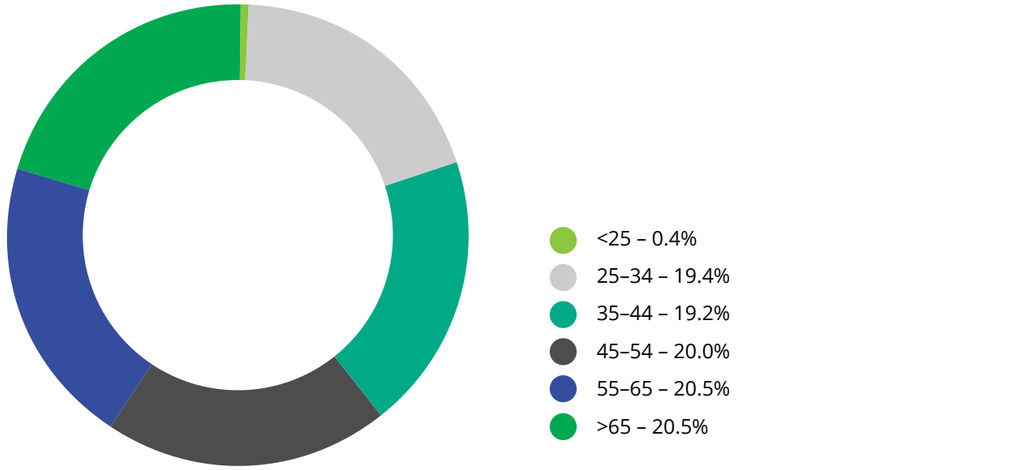
- TGA Medicine Shortages Working Party
- TGA Opioids Regulatory Communications Committee
- TGA Opioids Regulatory Advisory Group
- TGA Consultative Committee
- Reducing medicine-induced deterioration and adverse reactions (ReMInDAR)
- Stakeholder Advisory Committee
- ADHA Medicines Safety Program Steering Group
- National Quality Indicator Program for Aged Care working group
- Aged Care Quality and Safety Commission Minimizing the use of chemical restraints working group
- Australian Digital Health Agency Aged Care Advisory Group
- Residential Aged Care Funding Reform Working Group
- Victorian Aged Care Response Centre (VACRC) Stakeholders Working Group

MEMBERSHIP

Membership by type



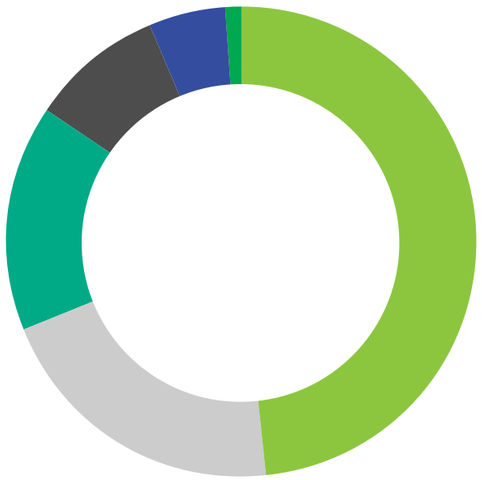
Membership by age



Membership by gender

- Male – 63%
- Female – 37%

Tenure of membership



- 1–10 – 47%
- 11–20– 20%
- 21–30 – 15%
- 31–40 – 9%
- 41–50 – 5%
- >50 – 4%

MEDIA

The President, the Vice President, and other AMA spokespeople promoted the AMA's position as the nation's leading voice of the medical profession in the media, with AMA policy and views reaching a potential audience of millions of readers, viewers, and listeners.

TRADITIONAL MEDIA

Total potential audience reach of 412,733,350.

Newspaper
930 articles

Radio
1928 interviews

Television
1137 appearances

Online
2587 articles

SOCIAL MEDIA

Facebook

Followers – 26,492

Comments – 10,542

Video views – 64,750

Facebook impressions – 3,694,313

TOP POST

Twitter

Followers – 28,687

Retweets – 16,489

Twitter impressions – 7,242,251

TOP POST

AMA SUBSIDIARIES

AMA Continuing Professional Development Tracker

In 2020, the AMA expanded support for its Continuing Professional Development (CPD) Tracker. As part of ongoing professional registration, all doctors are required to track and record completion of medical continuous professional development. Records must be kept for five years and can be audited by the Medical Board of Australia at any time to ensure ongoing registration. The AMA offers a simple-to-use online CPD Tracker, free to all members, as an alternative to CPD tracking with other organisations. Linked to the AMA's subsidiary company, doctorportal Learning Pty Ltd, which provides approved online learning content, the AMA CPD Tracker will become even more valuable to doctors in the years ahead as changes to CPD Home arrangements will allow greater choice in where medical continuous professional development can be undertaken and recorded.

AMA Fees List

The AMA has published the List of Medical Services and Fees annually since 1974. The online service, free to all AMA members, assists doctors in determining fees charged in the private medical practice. The Fees List is additionally used by some government bodies and insurers to inform payment for medical services. The AMA, during the course of 2020, invested further in the Fees List service by reviewing and adjusting certain item numbers, updating the Fees List to incorporate changes advised by the MBS Review and Department of Health, and looking at customer needs to improve online accessibility and utilisation of the Fees List by a broader customer base.

Doctors Health Services

The AMA plays a key role in promoting the good physical and mental health of doctors and medical students. In partnership with the Medical Board of Australia, the AMA receives and directs funding to service providers across Australia aimed at ensuring every medical practitioner and medical student has access to a General Practitioner trained in the unique care needs of treating another doctor. In partnership with the Commonwealth Department of Health, the AMA funds a national telehealth service providing mental health care to doctors and medical students. In 2020, the AMA reviewed these programs delivered through its subsidiary company Doctors Health Services. The review recommended expanded services informed by new performance benchmarks, to ensure any doctor and medical student can get even easier access to appropriate medical care by doctors trained in treating doctors.

Medical Journal of Australia

The nation's most important journal, the MJA, had an extraordinary year in 2020. Provided free to all AMA members, and read more widely within the Australian and international healthcare community, the MJA saw rapid growth in article submissions in 2020 and a targeted focus on clinical knowledge dissemination in the early stages of the global COVID-19 pandemic. The MJA experienced an average of over 335,000 monthly views online in 2020, and achieved an impact factor of 5.438, ranking the journal as among the top 16 general medical journals globally. The MJA during the year commenced its transition from print to digital publication, a transition of which will be completed during the next year. The move to digital editions will allow a more efficient means of getting peer reviewed knowledge to audiences faster, and opportunity to enhance access to and utilisation of the MJA's immense medical publishing material online.

FINANCIAL REPORT

2020

General Purpose Financial Report

Australian Medical Association Limited and Controlled Entities
ABN 37 008 426 793
For the financial year 31 December 2020

CONTENTS

Directors' REPORT

DIRECTORS

The names of directors in office during the financial year are as follows:

Dr Anthony Bartone
MBBS, FRACGP, MBA, FAMA
President
General Practitioner
(Board Member until 31 July 2020)

A/Professor Rosanna Capolingua
MBBS, FRACGP, FAMA, AICD, FAICD
Deputy Chair and Investment Committee member
General Practitioner

Dr Antonio Di Dio
MBBS (USYD) Dip RACOG FRACGP
General Practitioner
(Board Member since 18 June 2020)

Dr Iain Dunlop AM
MBBS (Hons), FRANZCO, FRACS, FAMA
Ophthalmologist
(Board Member until 17 June 2020)

Dr Stephen Gourley
MBBS, Grad Dip CE, MHM, MPH, FRCEM, FACEM, MAICD
Audit and Risk Committee member
Emergency Medicine

Dr Katherine Kearney
FRACP, BPharm, MBBS, MMed (Clin Epi)
Cardiologist
(Board Member since 18 June 2020)

Dr Omar Khorshid
MBBS, FRACS, FAOrthA, FAMA, AdvDipMgt, GAICD
President
Orthopaedic Surgeon
(Board Member since 1 August 2020)

Dr Bavahuna Manoharan
BSc (BioMed), MBBS, MPH, CHIA, GAICD
Audit and Risk Committee member (until 2020)
Candidate, Medical Administration

Dr Helen McArdle
BMedSc, MBBS, MPH, FAFOEM, FRACMA, FAICD
Audit and Risk Committee Chair
Specialist Medical Administrator and Occupational Physician

Dr Danielle McMullen
MBBS (Hons), FRACGP, DCH, GAICD
Investment Committee member (until 17 June 2020)
General Practitioner
(Board Member until 17 June 2020)

Dr Chris Moy
MBBS, FRACGP, FAMA
Vice President
General Practitioner
(Board Member since 1 August 2020)

A/Professor Gino Pecoraro
MB. BS, FRANZCOG, FAMA
Chair
Obstetrician & Gynecologist

Dr Gary Speck AM
MBBS, BMedSc (Hons), FRACS, FAOrthA, FAMA, GAICD
Investment Committee Chair
Orthopaedic Surgeon

A/Professor William Tam
MBBS, FRACP, PhD
Gastroenterologist

Dr Christopher Zappala
MBBS (Hons), GAICD, GCAE, AMusA, MHM, MD, FRACP, FAMA
Vice President
Thoracic and Sleep Physician
(Board Member until 31 July 2020)

PRINCIPAL ACTIVITIES

Australian Medical Association Limited (AMA) is a public company limited by guarantee. The AMA represents the interests of the registered medical practitioners of Australia and the medical students of Australia, and advocates on behalf of its members and their patients. The members of the AMA are simultaneously members of the State and Territory AMAs, which are separate legal entities.

The principal activities of the AMA Group (Group) during the reporting year, as set out in the Constitution, were to:

- preserve, maintain, promote and advance the intellectual, philosophical, social, political, economic and legal interests of Members; and
- promote the wellbeing of patients and take an active part in the promotion of health care programs for the benefit of the community and to participate in the resolution of major social and community health issues.

The AMA undertakes advocacy on behalf of its members and provides services and communications to its members. Through its subsidiaries, it publishes and circulates the *Medical Journal of Australia* and coordinates the provision of medical services to all medical practitioners and medical students. The consolidated Group owns investment assets held for long term funding requirements.

FINANCIAL RESULTS

Review and result of operations

In 2020, the consolidated Group recorded a total comprehensive income of $2.3 million (2019: $5.3 million). The 2020 profit figure includes $0.8 million of COVID-19 related government assistance for JobKeeper and cash flow boosts received during the year. As part of the Federal Government's business support package in response to COVID-19 during 2020, the Group received the cash flow boost stimulus; and its wholly-owned subsidiary, Australasian Medical Publishing Company Proprietary Ltd received the JobKeeper wage subsidy payments. In 2021, the Group no longer receives these Covid-19 related government assistance payments. In 2019, the profit figure included the disposal of direct investments in property amounting to $1.8 million.

The consolidated comprehensive income for the year, is net of accounting for changes in fair value of long-term investments that are reflective of valuation at reporting date. A lower performance in unrealised capital was recorded this year due to market sentiments largely because of the impact of COVID-19 on global equity markets. This result offsets recorded $1.2 million gains in 2019.

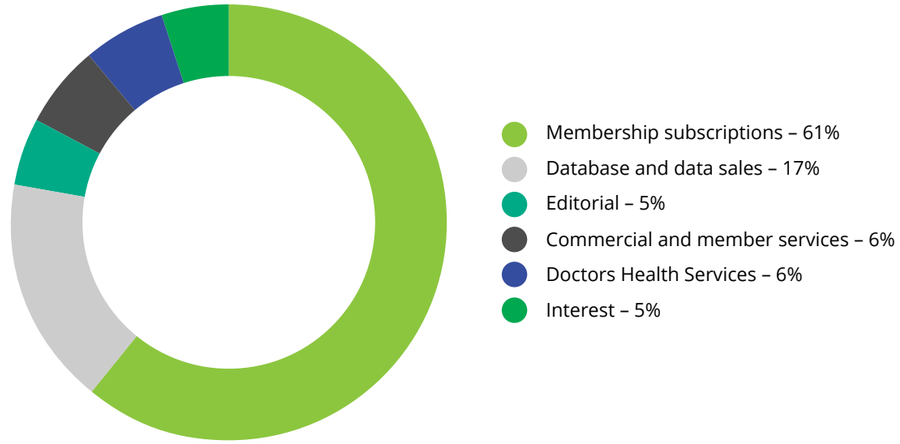
The Board's assessment is that the Group's investment portfolio, which is held for long term funding, is in a strong position to ride the downward trend and recover when markets rally. This volatility reinforces the importance of having a long-term view on capital management.

The Group's operations are largely unchanged apart from an immediate change to the format of meetings and the requirement for remote worksites, in line with Government requirements. At the time of reporting, there are no strong indicators that suggest a material financial impact to the Group's results in future financial years from on-going operations.

Revenue

Compared to 2019, total revenue from operations, excluding profit from sale of properties, has decreased by 4.8% (2019: increase 1.3%) to $21.9 million (2019: $23.0 million).

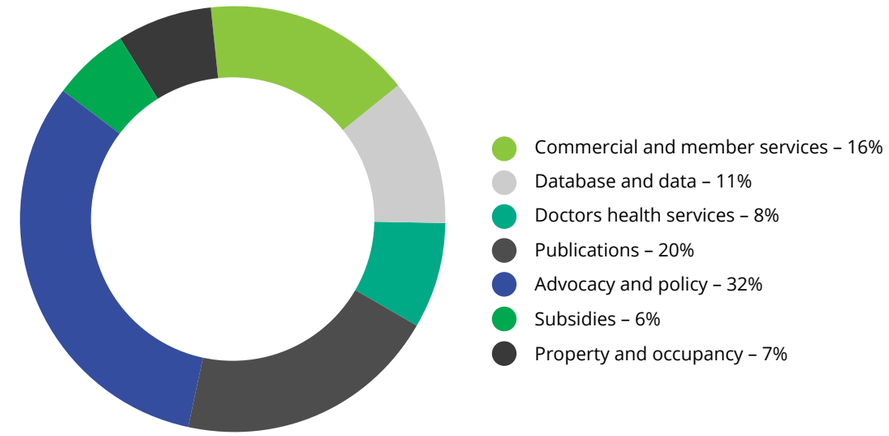
Graph 1 – Distribution of revenue in 2020



Expenses

Total expenses (before income tax) decreased by 5.7% (2019: decrease 6.7%) to $19.8 million (2019: $21.0 million).

Graph 2 – Distribution of expenses (excluding income tax)



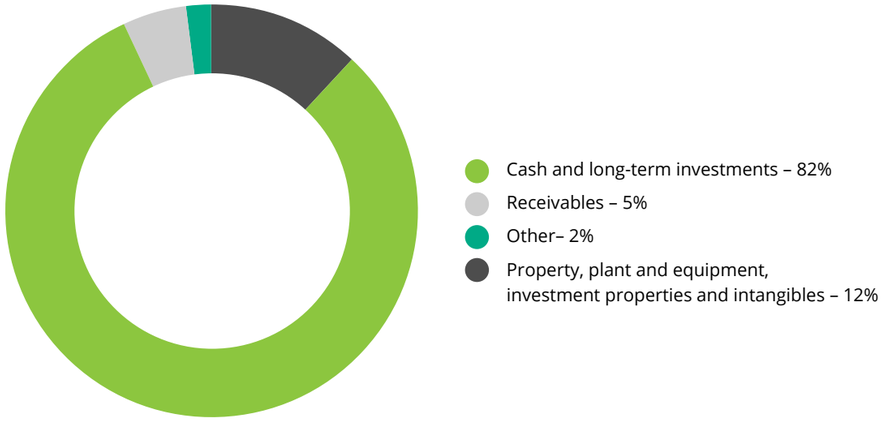
Review of financial position

Net assets increased 8.7% to $30.0 million compared to prior year (2019: increased 23.8% to $27.6 million)

Assets

Total assets increased 8.5% to $35.9 million compared to prior year (2019: $33.1 million). The sale of properties in 2019 has shifted the Group's direct holding of investment properties to holdings of financial assets for long term gain.

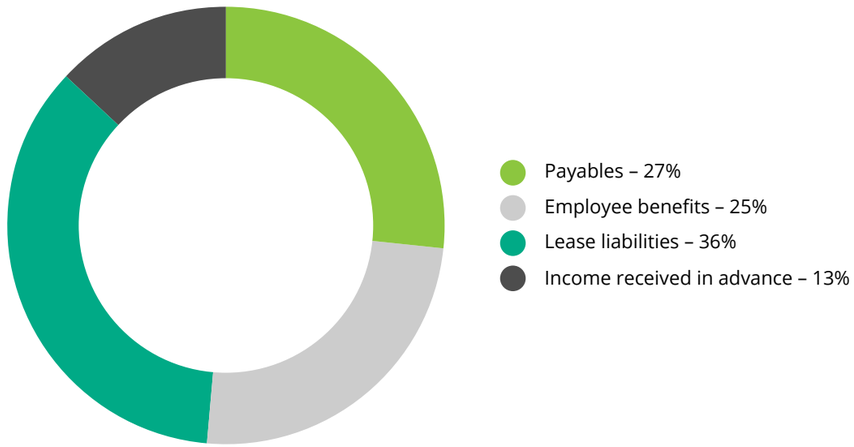
Graph 3 – Distribution of assets



Liabilities

Total liabilities increased 11.1% to $6.0 million compared to prior year (2019: $5.4 million)

Graph 5 Distribution of liabilities



ROUNDING

Amounts in the financial report have been rounded to the nearest thousand dollars ($'000).

DIVIDENDS

The Constitution of Australian Medical Association Limited does not permit the distribution of dividends to members.

STATE OF AFFAIRS

There was no significant change in the state of affairs of the Group during the financial year under review that is not disclosed in the financial statements.

STRATEGIC DIRECTION

During the reporting year the Board of Australian Medical Association Limited begun to implement its operational plan to achieve its strategic objectives for 2020-2023.

The strategic objectives support the AMA's mission of Leading Australia's Doctors – Promoting Australia's Health. The four pillars of the Board's strategic plan are:

1 – Value for Members

2 – Focused Advocacy

3 – Effective and Efficient Operations

4 – Improved Federation

The strategic objectives are delivered through an operational plan, which is reviewed and updated each year. The activities agreed for inclusion in the operational plan are funded in the budget.

AUDITOR'S INDEPENDENCE DECLARATION

A copy of the Auditor's independence declaration as required under s307C of the Corporations Act 2001 is set out on page 88.

INDEMNIFICATION AND INSURANCE OF OFFICERS AND AUDITORS

Indemnification

Since the end of the previous financial year, the Group has not indemnified or made a relevant agreement indemnifying against a liability of any person who is or has been an officer or auditor of the Group.

Insurance premiums

During the financial year the Group paid premiums in respect of Directors' and Officers' Liabilities and Professional Indemnity for the year ended 31 December 2020, insuring the directors of the company and all executive officers of the Group against a liability incurred by such a director or executive officer to the extent permitted by the Corporations Act 2001.

INFORMATION ON DIRECTORS

The Board is comprised of 11 medically qualified Directors and includes the President and Vice President, one Director nominated by each State and Territory AMA and one Director nominated by the AMA Council of Doctors in Training. The Chair is elected from among the Directors.

Under the Constitution, the Directors are required to be appointed based on their skills and experiences.

Directors' interests

Since the end of the previous financial year, no Director has received or become entitled to receive a benefit, other than a benefit included in the aggregate amount of remuneration received or due and receivable by Directors shown in the financial statements in Note 19.

DIRECTORS MEETING ATTENDANCE

During the period 1 January 2020 to 31 December 2020 the Board met on 12 occasions.

The Audit and Risk Committee met 5 times. Three members of the Committee are Directors and one is an independent appointment.

The Investment Committee met 5 times. All three members of the Committee are Directors.

The following tables summarises the meeting attendance of the Directors and Committee members during 2020, noting the number of meetings each Director/Committee member was eligible to attend and attended.

BOARD MEETINGS		
	ELIGIBLE TO ATTEND	ATTENDED
Dr Tony Bartone	7	7
Dr Chris Zappala	7	7
Dr Omar Khorshid	5	5
Dr Chris Moy	5	5
A/Prof Rosanna Capolingua	12	12
Dr Iain Dunlop	7	6
Dr Bavahuna Manoharan	12	12
Dr Helen McArdle	12	12
Dr Danielle McMullen	7	7
A/Prof Gino Pecoraro	12	12
Dr Gary Speck	12	12
A/Prof William Tam	12	12
Dr Stephen Gourley	12	12
Dr Katherine Kearney	7	7
Dr Antonio Di Dio	7	7

AUDIT, RISK AND PERFORMANCE COMMITTEE		
	ELIGIBLE TO ATTEND	ATTENDED
Dr Helen McArdle	5	5
Mr Ed Killesteyn	5	5
Dr Stephen Gourley	5	3
Dr Bavahuna Manoharan	4	2
Dr Antonio Di Dio	1	1

INVESTMENT COMMITTEE		
	ELIGIBLE TO ATTEND	ATTENDED
Dr Gary Speck	5	5
A/Prof Rosanna Capolingua	5	5
Dr Danielle McMullen	3	3

The AMA is a company limited by guarantee. If the AMA is wound up, each member of the AMA and each person who ceased to be a member in the preceding year, undertakes to contribute to the payment of debts and liabilities and the costs, charges and expenses of winding up the AMA, and the adjustments of rights of contributions amongst themselves, of an amount not exceeding two dollars.

Signed in accordance with a resolution of the Directors.

Dr Omar Khorshid

President
Australian Medical Association Limited

A/Prof Gino Pecoraro

Chair
Australian Medical Association Limited

STATEMENT OF COMPREHENSIVE INCOME

FOR THE YEAR ENDED 31 DECEMBER 2020

	Note	Consolidated 2020 $'000	2019 $'000
Revenue		20,287	22,014
Other income		1,641	2,779
	2	21,928	24,793
Expenses			
Employment		(12,378)	(12,025)
Publications		(977)	(1,347)
Database and data		(41)	(38)
Advocacy and policy		(507)	(1,271)
Subsidies	2	(1,227)	(1,054)
Commercial and member services		(107)	(81)
Doctors Health Services		(1,673)	(1,576)
Property and occupancy		(881)	(1,126)
Depreciation and amortisation		(409)	(339)
Administration	2	(1,551)	(2,137)
		(19,751)	(20,994)
Profit before income tax		2,177	3,799
Income tax credit/(expense)	4	256	327
Profit for the year		2,433	4,126
Other comprehensive income			
Changes in fair value of investments at fair value through other comprehensive income		(144)	1,687
Income tax relating to these items		46	(464)
Other comprehensive income for the year, net of tax		(98)	1,223
Total comprehensive income for the year		2,335	5,349

(Notes to and forming part of these financial statements are annexed)

STATEMENT OF FINANCIAL POSITION

AS AT 31 DECEMBER 2020

	Note	Consolidated 2020 $'000	2019 $'000
Assets			
Current assets			
Cash and cash equivalents	5	8,405	8,225
Trade and other receivables	6	1,742	1,552
Inventories	7	14	22
Prepayments	8	253	311
Financial investments	9	437	-
Total current assets		10,851	10,110
Non-current assets			
Financial investments	9	20,455	19,885
Intangible assets	10	1,790	874
Property, plant and equipment	11	518	650
Deferred tax assets	12	303	1
Right-of-use assets	13	2,026	1,567
Total non-current assets		25,092	22,977
Total assets		35,943	33,087
Liabilities			
Current Liabilities			
Trade and other payables	14	2,365	2,226
Lease liabilities	13	847	1,053
Employee benefits	15	1,352	1,144
Income tax payable	16	-	-
Total current liabilities		4,564	4,423
Non-current liabilities			
Employee benefits	15	112	111
Lease liabilities	13	1,283	904
Total non-current liabilities		1,395	1,015
Total liabilities		5,959	5,438
Net assets		29,984	27,649
Equity			
Retained earnings		29,693	27,260
Reserve		291	389
Total equity		29,984	27,649

(Notes to and forming part of these financial statements are annexed)

STATEMENT OF CHANGES IN EQUITY

FOR THE YEAR ENDED 31 DECEMBER 2020

Consolidated	Retained earnings $'000	Reserve $'000	Total Equity $'000
At 1 January 2019	23,134	(834)	22,300
Profit for the year	4,126	-	4,126
Other comprehensive income	-	1,223	1,223
Total comprehensive income for the year	4,126	1,223	5,349
At 31 December 2019	27,260	389	27,649
Profit for the year	2,433	-	2,433
Other comprehensive income	-	(98)	(98)
Total comprehensive income for the year	2,433	(98)	2,335
At 31 December 2020	29,693	291	29,984

(Notes to and forming part of these financial statements are annexed)

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 31 DECEMBER 2020

	Note	Consolidated 2020 $'000	2019 $'000
Cash flow from operating activities			
Receipts from membership subscriptions		13,356	13,999
Other receipts from customers		9,921	11,830
Payment to suppliers and employees		(20,712)	(23,364)
Interest received		41	72
Net cash flow from operating activities		2,606	2,537
Cash flow from investing activities			
Payments for intangible assets	10	(1,132)	(410)
Payments for property, plant and equipment	11	(64)	(62)
Proceeds from property, plant and equipment		-	2,828
Proceeds from investments		870	1,078
Payments for other investments		(1,151)	(1,011)
Net cash flow (used in)/from investing activities		(1,477)	2,423
Cash flow from financing activities			
Repayment of lease liabilities	13	(949)	(862)
Net cash flow used in financing activities		(949)	(862)
Net increase in cash held		180	4,098
Cash and cash equivalents at the beginning of the year		8,225	4,127
Cash and cash equivalents at the end of the year		8,405	8,225

(Notes to and forming part of these financial statements are annexed)

Note 1 Statement of Significant Accounting Policies

The consolidated financial statements and notes represent those of the Australian Medical Association Limited (AMA) and its controlled entities (the AMA Group).

The separate financial statements of the parent entity, Australian Medical Association Limited, have not been presented within this financial report as permitted by amendments made to the Corporations Act 2001.

Basis of preparation

The financial statements are general purpose financial statements that have been prepared in accordance with Australian Accounting Standards (including Australian Accounting Interpretations) of the Australian Accounting Standards Board (AASB) and the Corporations Act 2001. The financial statements comply with the Australian Accounting Standards - Reduced Disclosure Requirements as issued by the AASB. The AMA is a not for profit entity for financial reporting purposes under Australian Accounting Standards.

Australian Accounting Standards set out accounting policies that the AASB has concluded will result in financial statements containing relevant and reliable information about transactions, events and conditions. Compliance with Australian Accounting Standards ensures that the financial statements and notes also comply with International Financial Reporting Standards (IFRS). Material accounting policies adopted in the preparation of the financial statements are presented below and have been consistently applied unless otherwise stated.

The financial statements 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 financial statements were approved by the Board on 21 April 2021.

Note 1 Statement of Significant Accounting Policies (continued)

(a) Principles of consolidation

The consolidated financial statements incorporate the assets, liabilities and results of entities controlled by AMA at the end of the reporting period. A controlled entity is any entity that AMA Limited has the power to govern the financial and operating policies so as to obtain benefits from its activities.

Where controlled entities have entered or left the Group during the year, the financial performance of those entities is included only for the period of the year that they were controlled. A list of controlled entities is contained in Note 23 to the financial statements. In preparing the consolidated financial statements, all inter-group balances and transactions between entities in the consolidated group have been eliminated in full on consolidation.

Non-controlling interests, being the equity in a subsidiary not attributable, directly or indirectly, to a parent, are shown separately within the equity section of the consolidated statement of financial position and statement of comprehensive income. The non-controlling interests in the net assets comprise their interests at the date of the original business combination and their share of changes in equity since that date.

(b) Functional and presentation currency

These consolidated financial statements are presented in Australian dollars, which is the functional currency of the Group.

(c) Use of estimates and judgements

The preparation of financial statements requires management to make judgements, estimates and assumptions based on historical knowledge and best available current information that affect the application of accounting policies and the reported amounts of assets, liabilities, income and expenses. Estimates assume a reasonable expectation of future events and are based on current trends and economic data, obtained both externally and within the Group. Actual results may differ from these estimates.

Estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised and in any future periods affected.

Key estimates and judgements

Coronavirus (COVID-19) pandemic

Judgement has been exercised in considering the impacts that the Coronavirus (COVID-19) pandemic has had, or may have, on the consolidated entity based on known information. This consideration extends to the nature of the products and services offered, customers, supply chain, staffing and geographic regions in which the Group operates. Other than as addressed in specific notes, there does not currently appear to be either any significant impact upon the financial statements or any significant uncertainties with respect to events or conditions which may impact the consolidated entity unfavourably as at the reporting date or subsequently as a result of the Coronavirus (COVID-19) pandemic.

Note 1 **Statement of Significant Accounting Policies (continued)**

(c) Use of estimates and judgements (continued)

Revenue from contracts with customers involving sale of goods

When recognising revenue in relation to the sale of goods to customers, the key performance obligation of the Group is considered to be the point of delivery of the goods to the customer, as this is deemed to be the time that the customer obtains control of the promised goods and therefore the benefits of unimpeded access.

Allowance for expected credit losses

The allowance for expected credit losses assessment requires a degree of estimation and judgement. It is based on the lifetime expected credit loss, grouped based on days overdue, and makes assumptions to allocate an overall expected credit loss rate for each group. These assumptions include recent sales experience and historical collection rates.

Estimation of useful lives of assets

The Group determines the estimated useful lives and related depreciation and amortisation charges for its property, plant and equipment and finite life intangible assets. The useful lives could change significantly as a result of technical innovations or some other event. The depreciation and amortisation charge will increase where the useful lives are less than previously estimated lives, or technically obsolete or non-strategic assets that have been abandoned or sold will be written off or written down.

Impairment of non-financial assets other than goodwill and other indefinite life intangible assets

The Group assesses impairment of non-financial assets other than goodwill and other indefinite life intangible assets at each reporting date by evaluating conditions specific to the Group and to the particular asset that may lead to impairment. If an impairment trigger exists, the recoverable amount of the asset is determined. This involves fair value less costs of disposal or value-in-use calculations, which incorporate a number of key estimates and assumptions.

Income tax

The Group is subject to income taxes in the jurisdictions in which it operates. Significant judgement is required in determining the provision for income tax. There are many transactions and calculations undertaken during the ordinary course of business for which the ultimate tax determination is uncertain.

Employee benefits provision

The liability for employee benefits expected to be settled more than 12 months from the reporting date are recognised and measured at the present value of the estimated future cash flows to be made in respect of all employees at the reporting date. In determining the present value of the liability, estimates of attrition rates and pay increases through promotion and inflation have been taken into account.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

Note 1 **Statement of Significant Accounting Policies (continued)**

(d) Revenue recognition

Revenue is recognised for the major business activities upon satisfying the performance obligations, using the methods outlined below.

Membership subscription

Revenue from membership subscriptions is recognised in profit or loss in proportion to the stage of completion of the transaction at the reporting date. The stage of completion is determined by reference to the membership year.

Revenue from contracts with customers

Revenue is recognised at an amount that reflects the consideration to which the Group is expected to be entitled in exchange for transferring goods or services to a customer. For each contract with a customer, the Group: identifies the contract with a customer; identifies the performance obligations in the contract; determines the transaction price which takes into account estimates of variable consideration and the time value of money; allocates the transaction price to the separate performance obligations on the basis of the relative stand-alone selling price of each distinct good or service to be delivered; and recognises revenue when or as each performance obligation is satisfied in a manner that depicts the transfer to the customer of the goods or services promised.

Variable consideration within the transaction price, if any, reflects concessions provided to the customer such as discounts, rebates and refunds, any potential bonuses receivable from the customer and any other contingent events. Such estimates are determined using either the 'expected value' or 'most likely amount' method. The measurement of variable consideration is subject to a constraining principle whereby revenue will only be recognised to the extent that it is highly probable that a significant reversal in the amount of cumulative revenue recognised will not occur. The measurement constraint continues until the uncertainty associated with the variable consideration is subsequently resolved. Amounts received that are subject to the constraining principle are recognised as a refund liability.

Sale of goods

Revenue from the sale of goods is recognised at the point in time when the customer obtains control of the goods, which is generally at the time of delivery.

Rendering of services

Revenue from a contract to provide services is recognised over time as the services are rendered based on either a fixed price or contractual performance obligations.

Doctors Health Services

Doctors Health Services relates to the administration of government funding for distribution to doctors' health program providers and the Telehealth grant. Where performance obligations under the contract are not sufficiently specific, the Group recognises revenue when it gains control of (or has the right to receive) the asset (cash).

Rental income

Rental income is recognised in the statement of comprehensive income in the reporting period in which it is received, over the term of the lease in accordance with the lease agreement. Lease incentives granted are recognised as an integral part of the total rental income over the term of the lease.

Note 1 **Statement of Significant Accounting Policies (continued)**

(d) Revenue recognition (continued)

Interest income

Interest income from a financial asset is recognised when it is probable that the economic benefits will flow to the Group and the amount of revenue can be measured reliably.

Dividend income

Dividend income from investments is recognised when the shareholder's right to receive payment has been established (provided that it is probable that the economic benefits will flow to the Group and the amount of income can be measured reliably).

Grant income

Grant income is recognised in profit or loss when the Group satisfies the performance obligations stated within the funding agreements. If conditions are attached to the grant which must be satisfied before the Group is eligible to retain the contribution, the grant will be recognised in the statement of financial position as a liability until those conditions are satisfied.

(e) Finance income and expense

Finance income comprises interest income on funds invested. Interest income is recognised as it accrues in profit and loss, using the effective interest method.

Finance expenses comprise interest expense on borrowings. All borrowing costs are recognised in profit or loss using the effective interest method.

(f) Tax consolidation and income tax

The income tax expense or benefit for the period is the tax payable on that period's taxable income based on the applicable income tax rate for each jurisdiction, adjusted by the changes in deferred tax assets and liabilities attributable to temporary differences, unused tax losses and the adjustment recognised for prior periods, where applicable.

Deferred tax assets and liabilities are recognised for temporary differences at the tax rates expected to be applied when the assets are recovered or liabilities are settled, based on those tax rates that are enacted or substantively enacted, except for:

- When the deferred income tax asset or liability arises from the initial recognition of goodwill or an asset or liability in a transaction that is not a business combination and that, at the time of the transaction, affects neither the accounting nor taxable profits; or
- When the taxable temporary difference is associated with interests in subsidiaries, and the timing of the reversal can be controlled and it is probable that the temporary difference will not reverse in the foreseeable future.

Note 1 **Statement of Significant Accounting Policies (continued)**

(f) Tax consolidation and income tax (continued)

Deferred tax assets are recognised for deductible temporary differences and unused tax losses only if it is probable that future taxable amounts will be available to utilise those temporary differences and losses.

The carrying amount of recognised and unrecognised deferred tax assets are reviewed at each reporting date. Deferred tax assets recognised are reduced to the extent that it is no longer probable that future taxable profits will be available for the carrying amount to be recovered. Previously unrecognised deferred tax assets are recognised to the extent that it is probable that there are future taxable profits available to recover the asset.

Deferred tax assets and liabilities are offset only where there is a legally enforceable right to offset current tax assets against current tax liabilities and deferred tax assets against deferred tax liabilities; and they relate to the same taxable authority on either the same taxable entity or different taxable entities which intend to settle simultaneously.

Australian Medical Association Limited and its wholly-owned Australian subsidiaries formed an income tax consolidated group under the tax consolidation legislation with effect from 1 January 2011. Australian Medical Association Limited is the head entity of the Group.

Each entity in the Group recognises its own current and deferred tax assets and liabilities. Such taxes are measured using the 'separate taxpayer within group' approach to allocation. Current tax liabilities or assets and deferred tax assets arising from unused tax losses and tax credits in the subsidiaries are immediately transferred to the head entity.

The tax consolidated group has entered a tax funding arrangement whereby each company in the Group contributes to the income tax payable by the Group. Differences between the amounts of net tax assets and liabilities derecognised and the net amounts recognised pursuant to the funding arrangement are recognised as either a contribution by, or distribution to the head entity.

(g) Goods and services tax

Revenues, expenses and assets are recognised net of the amount of the Goods and Services Tax (GST), except where the amount of GST incurred is not recoverable from the taxation authority. In these circumstances, the GST is recognised as part of the cost of acquisition of the asset or as part of the expense.

Trade receivables and trade payables are stated with the amount of GST included. The net amount of GST recoverable from, or payable to, the Australian Tax Office (ATO) is included as a current liability in the statement of financial position. Other receivables and other payables are stated with the amount of GST excluded.

Cash flows are included in the statement of cash flows on a gross basis. The GST components of cash flows arising from investing and financing activities, which are recoverable from or payable to the ATO are classified as operating cash flows.

Commitments and contingencies are disclosed net of the amount of GST recoverable from, or payable to, the tax authority.

Note 1 **Statement of Significant Accounting Policies (continued)**

(h) Investments and other financial assets

Investments and other financial assets are initially measured at fair value. Transaction costs are included as part of the initial measurement, except for financial assets at fair value through profit or loss. Such assets are subsequently measured at either amortised cost or fair value depending on their classification. Classification is determined based on both the business model within which such assets are held and the contractual cash flow characteristics of the financial asset unless an accounting mismatch is being avoided.

Financial assets are derecognised when the rights to receive cash flows have expired or have been transferred and the consolidated entity has transferred substantially all the risks and rewards of ownership. When there is no reasonable expectation of recovering part or all of a financial asset, it's carrying value is written off.

Financial assets at fair value through profit or loss

Financial assets not measured at amortised cost or at fair value through other comprehensive income are classified as financial assets at fair value through profit or loss. Typically, such financial assets will be either: (i) held for trading, where they are acquired for the purpose of selling in the short-term with an intention of making a profit, or a derivative; or (ii) designated as such upon initial recognition where permitted. Fair value movements are recognised in profit or loss.

Financial assets at fair value through other comprehensive income

Financial assets at fair value through other comprehensive income include equity investments which the Group intends to hold for the foreseeable future and has irrevocably elected to classify them as such upon initial recognition.

Impairment of financial assets

The Group recognises a loss allowance for expected credit losses on financial assets which are either measured at amortised cost or fair value through other comprehensive income. The measurement of the loss allowance depends upon the Group's assessment at the end of each reporting period as to whether the financial instrument's credit risk has increased significantly since initial recognition, based on reasonable and supportable information that is available, without undue cost or effort to obtain.

Note 1 **Statement of Significant Accounting Policies (continued)**

(h) Investments and other financial assets (continued)

Where there has not been a significant increase in exposure to credit risk since initial recognition, a 12-month expected credit loss allowance is estimated. This represents a portion of the asset's lifetime expected credit losses that is attributable to a default event that is possible within the next 12 months. Where a financial asset has become credit impaired or where it is determined that credit risk has increased significantly, the loss allowance is based on the asset's lifetime expected credit losses. The amount of expected credit loss recognised is measured on the basis of the probability weighted present value of anticipated cash shortfalls over the life of the instrument discounted at the original effective interest rate.

For financial assets mandatorily measured at fair value through other comprehensive income, the loss allowance is recognised in other comprehensive income with a corresponding expense through profit or loss. In all other cases, the loss allowance reduces the asset's carrying value with a corresponding expense through profit or loss.

(i) Financial liabilities

Financial liabilities are recognised initially at fair value plus any attributable transaction costs. Subsequent to initial recognition, the financial liabilities are measured at amortised cost using the effective interest rate method. Financial liabilities comprise loans and borrowings, trade and other payables.

(j) 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 and bank overdrafts.

(k) Trade and other receivables

Trade and other receivables include amounts due from customers for goods sold and services performed 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.

(l) Trade and other payables

Trade and other payables represent the liabilities for goods and services received by the Group that remain unpaid at the end of the reporting period. The balance is recognised as a current liability with the amounts normally paid within 30 days of recognition of the liability.

(m) Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is based on the first-in first-out principle, and includes expenditure incurred in acquiring the inventories and bringing them to their existing location and condition. Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

Note 1 **Statement of Significant Accounting Policies (continued)**

(n) Property, plant and equipment

Recognition and measurement

Items of property, plant and equipment are measured at cost less accumulated depreciation and accumulated impairment losses.

Cost includes expenditures that are directly attributable to the acquisition of the asset. The cost of self-constructed assets includes the cost of materials and direct labour, any other costs directly attributable to bringing the asset to a working condition for its intended use and the costs of dismantling and removing the items and restoring the site on which they are located. Purchased software that is integral to the functionality of the related equipment is capitalised as part of that equipment.

When parts of an item of property, plant and equipment have different lives, they are accounted for as separate items (major components) of property, plant and equipment.

Gains and losses on disposal of an item of property, plant and equipment are determined by comparing the proceeds from disposal with the carrying amount of property, plant and equipment and are recognised net, within profit or loss.

Depreciation

Depreciation is recognised in profit or loss on a straight-line basis over the estimated useful lives of each part of an item of property, plant and equipment. Leased assets are depreciated over the shorter of the lease term and their useful lives. Land is not depreciated.

The estimated depreciation rates for the current and comparative periods are as follows:

	2020	2019
Buildings	**2.5% - 4%**	2.5% - 4%
Office Furniture	**5% - 25%**	5% - 25%
Office Equipment	**10% - 50%**	10% - 50%
Fixture and Fittings	**5%**	5%
Computer Hardware	**20% - 33.33%**	20% - 33.33%
Items less than $300	**100%**	100%

Depreciation methods, useful lives and residual values are reassessed at the reporting date.

Note 1 **Statement of Significant Accounting Policies (continued)**

(o) Intangible assets

Intangible assets that are acquired by the Group, which have finite lives, are measured at cost less accumulated depreciation and accumulated impairment losses.

Subsequent expenditure

Subsequent expenditure is capitalised only when it increases the future economic benefits embodied in the specific asset to which it relates. All other expenditure, including expenditure on internally generated goodwill and brands, is recognised in profit or loss when incurred.

Research and development

Research costs are expensed in the period in which they are incurred. Development costs are capitalised when it is probable that the project will be a success considering its commercial and technical feasibility; the Group is able to use or sell the asset; the Group has sufficient resources and intent to complete the development; and its costs can be measured reliably. Capitalised development costs are amortised on a straight-line basis over the period of their expected benefit.

Amortisation

Amortisation is calculated over the cost of the asset, or another amount substituted for cost, less its residual value.

Amortisation is recognised in profit or loss on a straight-line basis over the estimated useful lives of intangible assets, from the date that they are available for use. The estimated depreciation rates for the current and comparative periods are as follows:

	2020	2019
Development	**20% - 33.33%**	20% - 33.33%
Computer software	**10% - 25%**	10% - 25%

Amortisation methods, useful lives and residual values are reviewed at each financial year-end and adjusted if appropriate.

(p) Right-of-use assets and lease liabilities

Right-of-use assets

A right-of-use asset is recognised at the commencement date of a lease. The right-of-use asset is measured at cost, which comprises the initial amount of the lease liability, adjusted for, as applicable, any lease payments made at or before the commencement date net of any lease incentives received, any initial direct costs incurred, and, except where included in the cost of inventories, an estimate of costs expected to be incurred for dismantling and removing the underlying asset, and restoring the site or asset.

Right-of-use assets are depreciated on a straight-line basis over the unexpired period of the lease or the estimated useful life of the asset, whichever is the shorter. Where the consolidated entity expects to obtain ownership of the leased asset at the end of the lease term, the depreciation is over its estimated useful life. Right-of use assets are subject to impairment or adjusted for any remeasurement of lease liabilities.

The Group has elected not to recognise a right-of-use asset and corresponding lease liability for short-term leases with terms of 12 months or less and leases of low-value assets. Lease payments on these assets are expensed to profit or loss as incurred.

Note 1 **Statement of Significant Accounting Policies (continued)**

(p) Right-of-use assets and lease liabilities (continued)

Lease liabilities

A lease liability is recognised at the commencement date of a lease. The lease liability is initially recognised at the present value of the lease payments to be made over the term of the lease, discounted using the interest rate implicit in the lease or, if that rate cannot be readily determined, the Group's incremental borrowing rate. Lease payments comprise of fixed payments less any lease incentives receivable, variable lease payments that depend on an index or a rate, amounts expected to be paid under residual value guarantees, exercise price of a purchase option when the exercise of the option is reasonably certain to occur, and any anticipated termination penalties. The variable lease payments that do not depend on an index or a rate are expensed in the period in which they are incurred.

Lease liabilities are measured at amortised cost using the effective interest method. The carrying amounts are remeasured if there is a change in the following: future lease payments arising from a change in an index or a rate used; residual guarantee; lease term; certainty of a purchase option and termination penalties. When a lease liability is remeasured, an adjustment is made to the corresponding right-of use asset, or to profit or loss if the carrying amount of the right-of-use asset is fully written down.

(q) Impairment

Financial assets

Trade receivables

The Group applies the AASB 9 simplified approach to measuring expected credit losses which uses a lifetime expected loss allowance for all trade and other receivables.

To measure the expected credit losses, trade and other receivables have been grouped based on shared credit risk characteristics and the days past due. The historical loss rates are adjusted to reflect current and forward-looking information on macroeconomic factors affecting the ability of the customers to settle the receivables.

Trade receivables are written off when there is no reasonable expectation of recovery. Indicators that there is no reasonable expectation of recovery include, amongst others, the failure of a debtor to engage in a repayment plan with the Group.

Impairment losses on trade receivables are presented as net impairment losses within operating profit. Subsequent recoveries of amounts previously written off are credited against the same line item.

Investments

All of the Group's investments at amortised cost and FVOCI are considered to have low credit risk, and the loss allowance recognised during the period was therefore limited to 12 months expected losses. Management consider 'low credit risk' when they have a low risk of default and the issuer has a strong capacity to meet its contractual cash flow obligations in the near term.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

Note 1 **Statement of Significant Accounting Policies (continued)**

(r) Employee Benefits

Short-term benefits

Liabilities for employee benefits for wages and salaries (including superannuation), annual leave and long service leave represent present obligations resulting from employees' services provided to reporting date and are calculated at undiscounted amounts based on remuneration wage and salary rates that the Group expects to pay as at reporting date including related on-costs, such as workers compensation insurance and payroll tax.

Other long-term employee benefits

The Group's net obligation in respect of long-term employee benefits is the amount of future benefit that employees have earned in return for their service in the current and prior periods plus related on costs. That benefit is discounted to determine its present value and the fair value of any related assets is deducted. The discount rate is the yield at the reporting date on Commonwealth Government bonds that have maturity dates approximating the terms of the Group's obligations.

(s) Contract liabilities

Contract liabilities represent the Group's obligation to transfer goods or services to a customer and are recognised when a customer pays consideration, or when the Group recognises a receivable to reflect its unconditional right to consideration (whichever is earlier) before the Group has transferred the goods or services to the customer.

(t) Refund liabilities

Refund liabilities are recognised where the Group receives consideration from a customer and expects to refund some, or all, of that consideration to the customer. A refund liability is measured at the amount of consideration received or receivable for which the Group does not expect to be entitled and is updated at the end of each reporting period for changes in circumstances. Historical data is used across product lines to estimate such returns at the time of sale based on an expected value methodology.

(u) Parent entity financial information

The financial information for the Parent Entity, as disclosed in Note 22 has been prepared on the same basis as the consolidated financial statements, except as set out below.

Investments in controlled entities

Investments in controlled entities, are accounted for at cost in the financial statements of the Parent Entity. Dividends received from controlled entities are recognised in the Parent Entity's statement of comprehensive income.

(v) Comparative figures

When required by Accounting Standards, comparative figures have been adjusted to conform with changes in presentation for the current financial year. Comparatives are adjusted for reclassified items in the financial statements.

Note 2 Revenue and Expenses

	Consolidated	
	2020	2019
	$'000	$'000
Revenue		
Membership subscriptions	**12,232**	12,573
Database and data sales	**3,565**	3,081
Editorial	**907**	869
Commercial and member services	**1,262**	1,535
Doctors Health Services including Telehealth grant	**1,410**	2,773
Rental	**-**	33
Interest	**41**	72
Interest from investments at fair value through other comprehensive income	**870**	1,078
Other income		
Profit on sale of assets (Tourism House)	**-**	1,836
Government assistance - Jobkeeper	**587**	-
Government assistance - Cash flow boost	**257**	-
Other revenue including recoveries	**797**	943
	21,928	24,793
Expenses		
Contributions to employee superannuation plans	**930**	965
Cost of goods sold	**48**	23
Repairs and maintenance	**100**	29
Subsidies		
Subsidies to AMA States and Territories	**1,188**	1,016
Other subsidies	**39**	38
	1,227	1,054
Administration		
Loss on disposal of assets	**3**	2
Insurance	**83**	139
Travel and accommodation	**135**	473
Other	**1,330**	1,523
	1,551	2,137

Note 3 Auditor's Remuneration

	Consolidated	
	2020	2019
	$'000	$'000
Audit services		
Auditors of the Group		
RSM Australia Partners		
- Audit of financial report	**64**	63
Other services		
Auditors of the Group		
RSM Australia Pty Ltd		
- Taxation services	**20**	19
	84	82

Note 4 Income tax credit/(expense)

	Consolidated	
	2020	**2019**
	$'000	**$'000**
Current tax credit/(expense)		
Current tax on profits for the year	**-**	-
Prior year adjustments	**-**	9
	-	9
Deferred tax credit/(expense)		
Origination and reversal of temporary differences	**436**	364
Prior year adjustments	**(180)**	(46)
	256	318
Total income tax credit/(expense) in income statement	**256**	327
Profit before income tax	**(2,177)**	(3,799)
Income tax using the domestic corporation tax rate 26% (2019: 27.5%)	**(566)**	(1,045)
Increase in income tax expense due to:		
Mutual expenditure	**(2,910)**	(3,348)
Non-deductible expenses	**(1)**	(6)
Sundry	**(18)**	(4)
	(2,929)	(3,358)
Decrease in income tax expense due to:		
Mutual income	**3,743**	4,057
Fully franked dividends	**-**	120
Profit on sale of property - non assessable	**-**	505
Sundry	**188**	85
	3,931	4,767
Net change in income tax	**436**	364
Over provision for prior year - current tax expense	**-**	9
Under provision for prior year - deferred tax expense	**(180)**	(46)
	(180)	(37)
Income tax credit/(expense)	**256**	327
Attributable to:		
Continuing operations	**256**	327

Note 5 Cash and Cash Equivalents

		Consolidated	
		2020	**2019**
	Note	**$'000**	**$'000**
Cash at bank	17(b)	**5,055**	7,970
Short-term deposits (less than 3 months' maturity)	17(b)	**3,349**	254
Cash on hand		**1**	1
Total Cash and cash equivalents	17	**8,405**	8,225

(i) Classification of cash equivalents

Short-term deposits are presented as cash equivalents if they have a maturity of three months or less from the date of acquisition.

(ii) Restricted cash and short-term deposits

The cash and cash equivalents disclosed above and in the statement of cash flows include $1,307,000 (2019: $1,650,000), which are held by Doctors Health Services Pty Ltd. These monies are subject to grant funding arrangement restrictions and are therefore no available for general use by the other entities within the Group.

Note 6 Trade and other receivables

Trade receivables		**541**	417
Provision for impairment		**–**	–
		541	417
Other receivables		**1,201**	1,135
Total Trade and other receivables	17	**1,742**	1,552

(i) Classification as trade and other receivables

Trade receivables are amounts due from customers for goods sold or services performed in the ordinary course of business. Other receivables generally arise from transactions outside the usual operating activities of the Group. Collateral is not normally obtained. If collection of the amounts is expected in one year or less, they are classified as current assets. If not, they are presented as non-current assets. Trade receivables are generally due for settlement within 30 days and therefore are all classified as current. The Group holds the trade receivables with the objective to collect the contractual cash flows and therefore measures them subsequently at amortised cost using the effective interest method. The Group's impairment and other accounting policies for trade and other receivables are outlined in notes 1(k) and 1(q) respectively.

Note 7 Inventories

	Note	Consolidated 2020 $'000	Consolidated 2019 $'000
Finished goods		**14**	22
Total Inventories		**14**	22

Note 8 Prepayments

Prepayments		**253**	311
Total prepayments		**253**	311

Note 9 Financial investments

Current assets			
Financial assets at amortised cost			
Short-term deposits (more than 3 months' maturity)	17	**437**	-
Total Current		**437**	-
Non-current assets			
Financial assets at fair value through other comprehensive income			
Managed securities fund	17	**20,455**	19,885
Total Non-current		**20,455**	19,885
Total Financial investments		**20,892**	19,885

Note 9 Financial investments (continued)

(a) Financial assets at amortised cost

(i) Classification of financial assets at amortised cost

The Group classifies its financial assets as at amortised cost only if both of the following criteria are met:

- The asset is held within a business model whose objective is to collect the contractual cash flows; and
- The contractual terms give rise to cash flows that are solely payments of principal and interest.

(b) Financial assets at fair value through other comprehensive income

(i) Classification of financial assets at fair value through other comprehensive income

Financial assets at fair value through other comprehensive income (FVOCI) comprise:

- Equity securities which are not held for trading and which the Group has irrevocably elected at initial recognition to recognise in this category.
- Debt securities where the contractual cash flows are solely principal and interest and the objective of the Group's business model is achieved both by collecting contractual cash flows and selling financial assets.

(ii) Equity investments at fair value through other comprehensive income

On disposal of these equity investments, any related balance within the FVOCI reserve is reclassified to retained earnings.

(iii) Debt investments at fair value through other comprehensive income

On disposal of these debt investments, any related balance within the FVOCI reserve is reclassified to profit or loss.

(c) Financial assets at fair value through profit or loss

(i) Classification of financial assets at fair value through profit or loss

The Group classifies the following financial assets at fair value through profit or loss (FVPL):

- Debt investments that do not qualify for measurement at either amortised cost or FVOCI
- Equity investments that are held for trading; and
- Equity investments for which the entity has not elected to recognise fair value gains and losses through OCI.

Note 10 Intangible assets

	Consolidated	
	2020	2019
	$'000	$'000
Development - at cost	**752**	253
Less: Accumulated amortisation	**(194)**	(69)
	558	184
Computer software - at cost	**717**	693
Less: Accumulated amortisation	**(429)**	(337)
	288	356
Development in progress - at cost	**944**	334
Less: Accumulated amortisation	**-**	-
	944	334
Total Intangible assets	**1,790**	874

Movement in carrying amounts:

	Development	Computer software	Development in progress	Total
	$'000	$'000	$'000	$'000
31 December 2019				
Opening written down value	-	567	40	607
Additions	-	11	399	410
Transfer	240	(135)	(105)	-
Amortisation	(56)	(87)	-	(143)
Closing written down value	184	356	334	874
31 December 2020				
Opening written down value	**184**	**356**	**334**	**874**
Additions	**-**	**23**	**1,109**	**1,132**
Transfer	**499**	**-**	**(499)**	**-**
Amortisation	**(125)**	**(91)**	**-**	**(216)**
Closing written down value	**558**	**288**	**944**	**1,790**

Note 11 Property, plant and equipment

	Consolidated	
	2020	2019
	$'000	$'000
Property, Parap Rd, Parap - at cost	**381**	381
Less: Accumulated depreciation	**(89)**	(80)
	292	301
Office furniture - at cost	**570**	557
Less: Accumulated depreciation	**(524)**	(463)
	46	94
Office equipment - at cost	**866**	843
Less: Accumulated depreciation	**(763)**	(693)
	103	150
Fixtures and fittings - at cost	**91**	91
Less: Accumulated depreciation	**(59)**	(55)
	32	36
Computer hardware - at cost	**439**	426
Less: Accumulated depreciation	**(394)**	(357)
	45	69
Total Property, plant and equipment	**518**	650

An independent valuation of 2/25 Parap Road, Northern Territory was performed in December 2019 and valued at $310,000. Colliers International (NT) Pty Ltd prepared the valuation. As the valuation was in excess of the written down value disclosed in the financial statements, no adjustment is necessary nor has been made within the financial statements. It is the Group's accounting policy to obtain a valuation every 5 years.

Note 11 Property, plant and equipment (continued)

Movement in carrying amount:	Opening written down value	Additions	Disposals	Depreciation	Transfer	Closing written down value
Consolidated	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
31 December 2019						
Property, Parap Rd Parap	310	-	-	(9)	-	301
Office furniture	225	22	-	(72)	(81)	94
Office equipment	100	6	(2)	(35)	81	150
Fixture and fittings	41	-	-	(5)	-	36
Computer hardware	85	34	-	(69)	19	69
Personal computer network	25	-	-	(6)	(19)	-
	786	62	(2)	(196)	-	650
31 December 2020						
Property, Parap Rd Parap	**301**	**-**	**-**	**(9)**	**-**	**292**
Office furniture	**94**	**30**	**-**	**(104)**	**26**	**46**
Office equipment	**150**	**13**	**(2)**	**(32)**	**(26)**	**103**
Fixture and fittings	**36**	**-**	**-**	**(4)**	**-**	**32**
Computer hardware	**69**	**21**	**(1)**	**(44)**	**-**	**45**
	650	**64**	**(3)**	**(193)**	**-**	**518**

Note 12 Deferred tax assets and liabilities

	Deferred Tax Assets		Deferred Tax Liabilities		Total	
Consolidated	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**
	$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Leases	**-**	-	**(297)**	(193)	**(297)**	(193)
Property, plant and equipment	**-**	19	**(13)**	-	**(13)**	19
Income in advance	**-**	-	**(269)**	(382)	**(269)**	(382)
Employee benefits	**148**	132	**-**	-	**148**	132
Investments	**-**	-	**(102)**	(148)	**(102)**	(148)
Others	**47**	46	**-**	-	**47**	46
Carried forward losses	**789**	527	**-**	-	**789**	527
Total Deferred tax assets/(liabilities)	**984**	724	**(681)**	(723)	**303**	1

Movement in temporary differences:	Leases	Property, plant and equipment	Income in advance	Employee benefits	Investments	Others	Carried forward losses	Total
Consolidated	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
31 December 2019								
Opening written down value	(318)	(8)	(43)	140	316	60	-	147
Recognised in income statement	125	27	(339)	(8)	-	(14)	527	318
Recognised in equity	-	-	-	-	(464)	-	-	(464)
Closing written down value	(193)	19	(382)	132	(148)	46	527	1
31 December 2020								
Opening written down value	**(193)**	**19**	**(382)**	**132**	**(148)**	**46**	**527**	**1**
Recognised in income statement	**(104)**	**(32)**	**113**	**16**	**-**	**1**	**262**	**256**
Recognised in equity	**-**	**-**	**-**	**-**	**46**	**-**	**-**	**46**
Closing written down value	**(297)**	**(13)**	**(269)**	**148**	**(102)**	**47**	**789**	**303**

Note 13 Leases

	Consolidated	
	2020	2019
	$'000	$'000
(i) Amounts recognised in the balance sheet		
Assets		
Right-of-use assets - Office premises		
Opening written down value	**1,567**	2,362
Additions	**1,257**	-
Depreciation	**(798)**	(795)
Closing written down value	**2,026**	1,567
Liabilities		
Lease liabilities		
Current	**847**	1,053
Non-current	**1,283**	904
	2,130	1,957
(ii) Amounts recognised in the statement of profit or loss		
Interest expense	**61**	92
(iii) Amounts recognised in the statement of cash flows		
Lease payments	**949**	862

Note 14 Trade and other payables

Trade payables	**360**	465
Other payables and accruals	**1,236**	1,059
Income in advance	**769**	702
Total Trade and other payables	**2,365**	2,226

Note 15 Employee benefits

	Consolidated	
	2020	2019
	$'000	$'000
Current		
Long service leave provision	**526**	519
Annual leave provision	**826**	625
	1,352	1,144
Non-current		
Long service leave provision	**112**	111
Total Employee benefits	**1,464**	1,255

The employee benefits liability includes all of the accrued annual leave, the unconditional entitlements to long service leave where employees have completed the required period of service and also those where employees are entitled to pro-rata payments.

Note 16 Income tax payable

Income tax payable	-	-
Total Income tax payable	-	-

The income tax receivable/(payable) for the Group represents the amount of income taxes credit/(payable) in respect of current and prior periods.

Note 17 Financial Instruments and Risk Management

Risk management

The Board of Directors, through its Audit, Risk and Performance Committee and Investment Committee, manages the financial risks relating to the operations of the Group. The Group adopts prudent risk based management procedures. The Audit, Risk and Performance Committee oversees compliance with the Group's risk management procedures and the Investment Committee oversees financial asset management. The Group does not enter into or trade financial instruments for speculative purposes.

The Group's activities expose it to the following risks from the use of financial instruments:

(a) Credit risk

Credit risk refers to the risk that a counter party will default on its contractual obligations resulting in financial loss to the Group. The Group has adopted the policy of only dealing with credit worthy counter parties and obtaining sufficient collateral or other security where appropriate as a means of mitigating the risk of financial loss from defaults.

The carrying amount of the Group's financial assets represents the maximum credit exposure.

		Consolidated	
		2020	2019
	Note	$'000	$'000
Financial assets			
Cash and cash equivalents	5	**8,405**	8,225
Trade and other receivables	6	**1,742**	1,552
Financial assets at amortised costs	9	**437**	-
Financial assets at fair value through other comprehensive income	9	**20,455**	19,885
		31,039	29,662

The Group does not have any significant credit risk exposure to any single counterparty or any group of counterparties having similar characteristics. The carrying amount of financial assets recorded in the financial statements, net of any allowances for losses, represents the Group's maximum exposure to credit risk.

The other classes within trade and other receivables do not contain impaired assets and are not past due. Based on the credit history of these other classes, it is expected that these amounts will be received when due. The Group does not hold any collateral in relation to these receivables.

Note 17 Financial Instruments and Risk Management (continued)

(b) Market risk

Market risk is the risk that changes in market prices such as currency rates, interest rates and equity prices will affect the Group's income. The objective of market risk management is to manage and control market risk exposure within acceptable parameters whilst optimising returns.

(i) Interest risk

At the reporting date the interest rate profile of the Group's interest-bearing financial instruments was:

		Consolidated	
		2020	2019
	Note	$'000	$'000
Variable rate instruments			
Financial assets			
Cash at bank	5	**5,055**	7,970
		5,055	7,970
Fixed rate instruments			
Financial assets at amortised costs			
Short term deposits			
- less than 3 months' maturity	5	**3,349**	254
- more than 3 months' maturity	9	**437**	-
		3,786	254

(ii) Currency risk

Currency risk is the risk that the future cash flows of a financial instrument will fluctuate because of changes in foreign currency. The Group's exposure to currency rate risk is immaterial as the Group trades predominantly in Australian dollars.

Note 17 Financial Instruments and Risk Management (continued)

(b) Market risk (continued)

(iii) Price risk

	Note	Consolidated 2020 $'000	2019 $'000
Financial assets			
Non-current assets			
Financial assets at fair value through other comprehensive income			
Managed fund - Australian securities		**13,472**	12,169
Managed fund - International securities	9	**6,983**	7,716
		20,455	19,885

Exposure

Certain investments are designated as at fair value through profit and loss as these are short term investments that are primarily for meeting operational expenditure. The Group's exposure to equity securities price risk arises from investments held by the Group and classified in the balance sheet as at fair value through other comprehensive income (FVOCI). The main purpose of FVOCI investments are to provide long term funding to the Group. While income and realised capital gains may be used to meet shortfalls in operational expenditure, ordinarily though, the income and any realised capital gains generated are expected to be retained for reinvestment.

To manage its price risk arising from investments, the Group diversifies its portfolio through managed funds, assisted by external advisers and endorsed by the Board through its Investment Committee.

(c) Liquidity risk

Liquidity risk is the risk that the Group will not be able to meet its normal financial obligations as they fall due. The Group manages liquidity risk by maintaining adequate reserves and banking facilities and by continuously monitoring forecast and actual cash flows.

(d) Fair values versus carrying amount

The fair values of financial assets and liabilities, are not significantly different from the carrying amounts shown in the Statement of Financial Position.

(e) Capital management

The Group maintains a strong funding structure so as to enable it to continue operations to promote its core objectives. The strong funding structure is maintained through the optimisation of banking facilities and the preservation of revenue.

Note 18 Commitments

	Consolidated 2020 $'000	2019 $'000
Expenditure commitment:		
Not later than 1 year	**207**	50
Later than 1 year but not later than 5 years	**-**	25
	207	75
Commitments receivable		
Not later than 1 year	**35**	67
Later than 1 year but not later than 5 years	**-**	35
	35	102

Note 19 Directors and Executive disclosure

During the year the Group paid a premium to insure the Directors and Officers of the Group as disclosed in the Directors Report.

The Directors and Key Management Personnel are remunerated in the form of salaries or under contract as follows.

	Consolidated 2020 $'000	2019 $'000
Total remuneration	**3,373**	3,050

Apart from the details disclosed in this note, no Director has entered into a material contract with the Group since the end of the previous financial year and there were no material contracts involving Directors' interests subsisting at year end.

Note 20 Trust funds

The Group manages monies held in trust for a number of funds. The net values of the assets of those funds are as follows:

	Consolidated	
	2020	**2019**
	$'000	**$'000**
The Indigenous Peoples' Medical Scholarship Trust Fund	**61,005**	70,896
The AMA Indigenous Medical Scholarship Foundation	**190,717**	167,167
	251,722	238,063

AMA Pty Limited acts as trustee for the Indigenous Peoples' Medical Scholarship Trust Fund and the AMA Indigenous Medical Scholarship Foundation. However, as the Fund does not have a Deductible Gift Recipient (DGR) status, a new DGR and Australian Charities and Not-for-profits Commission (ACNC) compliant fund, the AMA Indigenous Medical Scholarship Foundation, was established in 2016. It provides scholarships to assist Aboriginal and Torres Strait Islander people in tertiary courses at Australian universities, undertaking courses of study leading to registration as a medical practitioner.

Note 21 Subsequent events

In April 2021, AMA Limited entered into a lease agreement to lease a new office space. The new lease has a 12-year term, which will commence in July 2021 and has a total contract value of approximately $7.4 million. The new lease provides a rent-free incentive that allows AMA Limited to continue to occupy the current office premise on Level 4, 42 Macquarie Street, Barton in ACT, until the lease expiry in November 2022 or when the lessor releases AMA Limited from the lease with no penalty claim, whichever is earlier.

Note 22 Parent entity

As at, and throughout the financial year ended 31 December 2020, the parent company of the Group was the Australian Medical Association Limited. The following information has been extracted from the books and records of the parent and has been prepared in accordance with the accounting standards.

	2020	**2019**
	$'000	**$'000**
(a) Financial information		
Earnings before interest and tax	**(487)**	(958)
Interest income	**799**	1,015
Profit before tax	**312**	57
Trust distribution - AMA Property Trust	**7,011**	-
Income tax credit/(expense) *	**256**	319
Profit for the year	**7,579**	376
Changes in fair value of investments at fair value through other comprehensive income (net of income tax)	**(62)**	1,015
Total comprehensive profit	**7,517**	1,391

* The parent entity, the Australian Medical Association Limited, is the head entity for the income tax consolidated group and it provides income tax subsidies to its subsidiary companies within the Group.

Note 22 Parent entity (continued)

	2020 $'000	2019 $'000
Statement of financial position		
Assets		
Current assets	**5,504**	5,623
Non-current assets	**20,475**	29,099
Total assets	**25,979**	34,722
Liabilities		
Current liabilities	**2,090**	2,015
Non-current liabilities	**1,591**	17,926
Total liabilities	**3,681**	19,941
Equity		
Retained earnings	**22,073**	14,494
Reserve	**225**	287
Total equity	**22,298**	14,781

(b) Other commitments

There have been no contractual commitments entered into by the Australian Medical Association Limited for the acquisition of property, plant or equipment.

(c) Contingent liabilities

There are no contingent liabilities at the reporting date.

Note 23 Related party transactions

Subsidiaries

Interests in subsidiaries are set out below.

	Consolidated 2020 $'000	Consolidated 2019 $'000
Parent entity		
Australian Medical Association Limited	**n/a**	n/a
Controlled entities		
Australasian Medical Publishing Company Proprietary Limited	**1**	1
AMA Pty Limited	**2**	2
AMA NT Pty Ltd	**1**	1
Doctors Health Services Pty Ltd	**1**	1
Doctorportal Learning Pty Ltd	**1**	1
Actraint No. 110 Pty Limited	**-**	2
	6	8

'The consolidated financial statements incorporate the assets, liabilities and results of the following subsidiaries in accordance with the accounting policy described in Note 1.

Name of entity	Class of shares	Equity holding 2020 %	Equity holding 2019 %
Australasian Medical Publishing Company Proprietary Limited	Ordinary	**100**	100
AMA Pty Limited	Ordinary	**100**	100
AMA NT Pty Ltd	Ordinary	**100**	100
Doctors Health Services Pty Ltd	Ordinary	**100**	100
Doctorportal Learning Pty Ltd	Ordinary	**100**	100
Actraint No 110 Pty Ltd	Ordinary	**-**	100

Note 23 **Related party transactions (continued)**

The parent entity, the Australian Medical Association Limited, is a company limited by guarantee, incorporated and domiciled in Australia. The registered office of the Company is 4th Floor, 42 Macquarie Street, Barton ACT 2600. The Company promotes the interests of the medical profession in the medico political arena and also in the more general sphere, advocates for patient health and the health of the community.

Australasian Medical Publishing Company Proprietary Limited is a company limited by shares, incorporated and domiciled in Australia. The registered office of this company is Level 19, Town Hall House, 456 Kent St, Sydney NSW 2000. This company publishes the Medical Journal of Australia and maintains and operates a comprehensive database containing both member and non-member information.

AMA Pty Limited is a company limited by shares, incorporated and domiciled in Australia. The registered office of this company is 4th Floor, 42 Macquarie Street, Barton ACT 2600. This company acts as trustee for the AMA Property Trust. The Trust owns, manages and rents commercial properties in Barton, ACT. AMA Property Trust has wound up during the financial year. AMA Pty Limited also acts as trustee for the Indigenous Peoples' Medical Scholarship Trust Fund and the AMA Indigenous Medical Scholarship Foundation.

AMA NT Pty Ltd is a company limited by shares, incorporated and domiciled in Australia. The registered office of this company is 4th Floor, 42 Macquarie Street, Barton ACT 2600. This company purchased a commercial property in Darwin, Northern Territory on 1 February 2011 and provided services to members of the AMA in the Northern Territory from 1 November 2011.

Doctors Health Services Pty Ltd is a company limited by shares, incorporated and domiciled in Australia. The registered office of this company is 4th floor, 42 Macquarie Street, Barton, ACT 2600. This company manages the delivery of health services for medical practitioners and medical students. In 2019, the company and the Department of Health entered into a Telehealth agreement to support the delivery of mental health consultation services for doctors and medical students.

Doctorportal Learning Pty Ltd is a company limited by shares, incorporated and domiciled in Australia. The registered office of this company is 4th floor, 42 Macquarie Street, Barton, ACT 2600. This company manages the delivery of online accredited medical education for both members and non-members.

Actraint No 110 Pty Limited is a company limited by shares, incorporated and domiciled in Australia. The registered office of this company is 4th Floor, 42 Macquarie Street, Barton ACT 2600. This company acts as trustee for the AMA Investment Trust. Actraint No 110 Pty Limited and AMA Investment Trust have been wound up during the financial year.

Directors' DECLARATION

In the directors' opinion:

1. the attached financial statements and notes comply with the Corporations Act 2001, the Australian Accounting Standards - Reduced Disclosure Requirements, the Corporations Regulations 2001 and other mandatory professional reporting requirements;
2. the attached financial statements and notes give a true and fair view of the Group's financial position as at 31 December 2020 and of its performance for the financial year ended on that date;
3. there are reasonable grounds to believe that the Group will be able to pay its debts as and when they become due and payable; and

Signed in accordance with a resolution of directors made pursuant to section 295(5)(a) of the Corporations Act 2001

On behalf of the directors

Dr Omar Khorshid
President
Australian Medical Association Limited

A/Prof Gino Pecoraro
Chair
Australian Medical Association Limited

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AUDITOR'S INDEPENDENCE DECLARATION

As lead auditor for the audit of the financial report of Australian Medical Association Limited and its Controlled Entities for the year ended 31 December 2020, I declare that, to the best of my knowledge and belief, there have been no contraventions of:

(i) the auditor independence requirements of the *Corporations Act 2001* in relation to the audit; and

(ii) any applicable code of professional conduct in relation to the audit.

RSM AUSTRALIA PARTNERS

RODNEY MILLER
Partner

Canberra, Australian Capital Territory
Dated: 22 April 2021

RSM Australia Partners

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INDEPENDENT AUDITOR'S REPORT

TO THE MEMBERS OF

AUSTRALIAN MEDICAL ASSOCIATION LIMITED

Opinion

We have audited the financial report of Australian Medical Association Limited (the Company) and its subsidiaries (the Group), which comprises the consolidated statement of financial position as at 31 December 2020, the consolidated statement of comprehensive income, the consolidated statement of changes in equity and the consolidated statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies, and the directors' declaration.

In our opinion the accompanying financial report of the Group is in accordance with the Corporations Act 2001, including:

(i) giving a true and fair view of the Group's financial position as at 31 December 2020 and of its financial performance for the year then ended; and

(ii) complying with Australian Accounting Standards – Reduced Disclosure Requirements and the Corporations Regulations 2001.

Basis for Opinion

We conducted our audit in accordance with Australian Auditing Standards. Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of our report. We are independent of the Group in accordance with the auditor independence requirements of the Corporations Act 2001 and the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to our audit of the financial report in Australia. We have also fulfilled our other ethical responsibilities in accordance with the Code.

We confirm that the independence declaration required by the Corporations Act 2001, which has been given to the directors of the Company, would be in the same terms if given to the directors as at the time of this auditor's report.

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

Other Information

The directors are responsible for the other information. The other information comprises the information included in the Group's annual report for the year ended 31 December 2020 but does not include the financial report and the auditor's report thereon.

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Our opinion on the financial report does not cover the other information and accordingly we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial report, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial report or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Responsibilities of the Directors for the Financial Report
The directors of the Company 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 and the Corporations Act 2001 and for such internal control as the directors determine is necessary to enable the preparation of the financial report that gives a true and fair view and is free from material misstatement, whether due to fraud or error.

In preparing the financial report, the directors are responsible for assessing the ability of the Group to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the Group or to cease operations, or have no realistic alternative but to do so.

Auditor's Responsibilities for the Audit of the Financial Report
Our objectives are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

A further description of our responsibilities for the audit of the financial report is located at the Auditing and Assurance Standards Board website at: http://www.auasb.gov.au/Pronouncements/Australian-Auditing-Standards/Auditors-Responsibilities.aspx. This description forms part of our auditor's report.

RSM AUSTRALIA PARTNERS

Canberra, Australian Capital Territory
Dated: 22 April 2021

RODNEY MILLER
Partner

AMA

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