ANNUAL REPORT 2021

AMA

Australian Medical Association
Annual Report 2021
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CONTENTS

PRESIDENT'S REPORT

DR OMAR KHORSHID
Federal AMA President

For most of the last year, I've conducted my Presidency from within the closed border of Western Australia. COVID-19 has disrupted the lives of so many, and for me it has meant a very different method of fulfilling my obligations to AMA members.

While inconvenient for me, COVID-19 has caused a massive disruption for the usual work of doctors. Interruption of regular care during lockdowns, suspension of surgery as hospitals pivoted to COVID-19 care, and the scale of the COVID-19 vaccine program have stretched doctors to their limits. Two years into the pandemic, I don't know a doctor who is not pandemic fatigued.

Aware to these pandemic-caused pressures, the AMA in the last twelve months has delivered tangible pandemic management outcomes that have eased the COVID-19 load of the medical profession. Specifically, the AMA:

- proposed and secured a no fault COVID-19 vaccine indemnity scheme.
- secured permanent telehealth to enable ongoing General Practice and other Specialist patient access by phone and video.
- improved funding arrangements for General Practice to deliver the COVID-19 vaccine scheme.

My Vice President Dr Chris Moy and I have additionally used the power of the AMA's advocacy voice to keep COVID-19 government decision making honest. We've seen elective surgery suspensions lifted after AMA advocacy, just as we've seen public health measures adjusted in response to AMA advocacy.

Beyond COVID-19, our advocacy focus has delivered much more as you will read in these pages, including a strengthening of the operation of the prostheses list, with Health Minister Greg Hunt implementing the AMA's proposal over that of others who sought a Diagnosis Related Groups (DRG) pricing framework and relief to participants of the Bonded Medical Placement program, who in the absence of the AMA would have had massive financial penalties imposed.

In a new approach for AMA advocacy, I have led the establishment of three key campaigns that are currently underway in 2022.

The first to commence was *#Sickly-Sweet*, an initiative aimed at reduction in consumption of sugary beverages by targeting the general public with obesity health messages and proposing to the Federal Government a sugary beverage tax.

The second was *Clear the hospital logjam*. For years, the AMA has reported on overcrowded public hospitals. This new campaign seeks changes to Federal funding of State and Territory run hospitals in return for States also lifting their funding and performance obligations. The campaign has placed public hospital funding firmly on the national agenda, and momentum for a new national funding agreement is unstoppable.

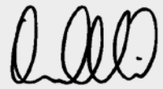
The third aims to improve resourcing of primary care. Our *Modernise Medicare* initiative responds to the failure of the Federal Government to fund the Ten-Year Plan for Primary Care and the long known financial sustainability pressures that confront General Practice.

As I approach the final phase of my own Presidency, I thank the AMA Federal Council who have met more often than usual during the pandemic to inform policy responses to the arrival of new virus variants and the frequent disruptions that medical practice has encountered. Federal Council Chair A/Prof Julian Rait has steered the Council expertly through a difficult period.

I thank the Board of AMA Ltd, who have hauled in our expenditure while enabling the Federal Secretariat to approach their work on campaigns and health economics in new and innovative ways. AMA Ltd Board Chair A/Prof Rosanna Capolingua is to be commended on her leadership during a period where the Board has been unable to meet in person.

I thank our Federal Secretariat staff in Canberra, who have worked to support me in my role, despite us rarely being in the same room. I thank Dr Chris Moy, who has worked harder than any AMA Vice President before him and has become a regular cut through voice on TV and radio news.

Most of all, I thank every AMA member for your support of our profession. The AMA fights for every doctor, but it can only do so with the support of AMA members.



Dr Omar Khorshid

Federal President
Australian Medical Association Limited

'We've seen elective surgery suspensions lifted after AMA advocacy, just as we've seen public health measures adjusted in response to AMA advocacy.'

CHAIR OF THE BOARD'S REPORT

A/PROF ROSANNA CAPOLINGUA

Chair, AMA Ltd Group of Companies

The relevance of the AMA to doctors and patients was proven once again over the last year. As the medical profession worked through the second year of COVID-19, the AMA fought for the interests of the medical profession and used its voice to give confidence to a worried public on navigating the pandemic.

The AMA President Dr Omar Khorshid and Vice President Dr Chris Moy have worked tirelessly and at great personal toll to ensure the Federal Government's pandemic response was evidence based, put patients first and supported doctors in their front-line role. Dr Khorshid and Dr Moy, for the benefit of all doctors alike, negotiated and secured the COVID-19 vaccine no fault indemnity scheme, the embedding of telehealth in the Medicare Benefits Schedule (MBS), and evolving arrangements for the MBS to cement the role of General Practice in the COVID-19 vaccine program.

The AMA President additionally refreshed the method by which the AMA advocates on behalf of its members, by initiating three campaigns seeking to:

- *Modernise Medicare* in order to restore General Practice's financial sustainability;
- *Clear the hospital logjam* by having the Federal Government increase its funding contribution to State and Territory run public hospitals; and
- tax sugary beverages to reduce obesity through the *#Sickly-Sweet* initiative.

These campaigns are working, and will inform how the AMA can strengthen its advocacy for doctors.

The President and Vice President, together with the AMA Federal Council, Federal Board and Federal Secretariat staff, have carried out their work on behalf of AMA members despite pandemic roadblocks. Closed state borders, travel restrictions, work from home directions and the reality of mandatory isolation and virus infection have not hampered the AMA's work. Increased technology use, flexible working arrangements and media via Zoom has in fact made the AMA more efficient.

To support the needs of AMA members, the Association's organisational capacity has been in a process of reform over the last year. Our Federal Secretariat has bedded down its three teams of Policy, Advocacy and Corporate Services. Within the Advocacy Team in particular:

- the Research and Reform Unit has informed much of the President's advocacy;
- the Fees List service has been refreshed; and
- campaigns are being delivered with the support of the Information Technology Unit.

The Association's three main subsidiaries have also been subject to reform over the last year:

- the Australasian Medical Publishing Company (AMPCo) transitioned the Medical Journal of Australia (MJA) from its previous printed format to different online options;
- Doctors Health Services Pty Ltd secured Commonwealth resources to implement the *Every Doctor, Every Setting* initiative to promote better mental health of doctors and medical students; and
- Doctor Portal Learning was transitioned to the ownership of AMA WA to ensure continued access of all AMA members to online professional development and potential future access to the AMA as a CPD Home.

The reforms of the Federal Secretariat and its three main subsidiaries have seen the AMA achieve efficiencies in forecast expenditure growth.

The 2020 decision of the AMA Ltd Board to reduce its recurrent costs by one fifth has been achieved, perhaps best demonstrated by the decision to reduce AMPCo rented accommodation and relocate the Federal Secretariat to new premises that deliver rental cost savings of more than a third.

Reforms, plus travel cost savings arising from COVID-19, have allowed the AMA Group of companies to report consolidated comprehensive income of $2.5 million for the year.

This result well positions the AMA to continue its work for members.

To the members of the AMA Ltd Board and its Committees, I extend my gratitude as Chair. Not having been able to meet in person has been less than ideal, but good governance has been made possible by the input of Directors virtually.

To the AMA and AMPCo staff teams in Canberra and Sydney, I commend you for your efforts, particularly during the three long stints of work from home of the last twelve months. But to our President and Vice President in particular, your efforts on behalf of the AMA through possibly its busiest period ever have been heroic.

Every member of the AMA can know the AMA has fought for you and your patients over the last year, and delivered outcomes that had it not been for the AMA would not have been achieved.

A/Prof Rosanna Capolingua

Chair,
AMA Ltd Group of Companies

'The 2020 decision of the AMA Ltd Board to reduce its recurrent costs by one fifth has been achieved.'

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

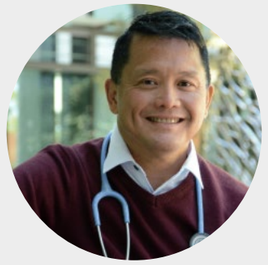
EFFECTIVE & EFFICIENT OPERATIONS

- 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 presidents and CEOs.
- Determine accountabilities of federal, state, and territory bodies

LEADERSHIP

AMA LTD BOARD UNTIL 27 MAY 2021

DR OMAR KHORSHID
President



DR CHRIS MOY
Vice President

A/PROF GINO PECORARO
Chair

A/PROF ROSANNA CAPOLINGUA
Deputy Chair

DR ANTONIO DI DIO

DR BAVAHUNA MANOHARAN

DR HELEN MCARDLE

DR KATE KEARNEY

DR GARY SPECK

A/PROF WILLIAM TAM

DR STEPHEN GOURLEY

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Dr Chris Moy	Vice President
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Associate Professor Gino Pecoraro	Board Chair
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Dr Dilip Dhupelia	QLD
Dr Michelle Atchison	SA/NT
Dr Annette Barratt	TAS
Dr Eugenie Kayak	VIC
Dr Katharine Noonan	WA
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Prof Steve Robson	Obstetricians and Gynaecologists
Dr Peter Sumich	Ophthalmologists
Dr Sarah Coll	Orthopaedic Surgeons
Dr Paul Bauert	Paediatricians
Dr Daniel Owens	Pathologists
Dr Matthew McConnell	Physicians
A/Prof Jeffrey Looi	Psychiatrists
Dr Brendan Adler	Radiologists
Prof Owen Ung	Surgeons
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Dr Richard Kidd	Council of General Practice
Dr Marco Giuseppin	Council of Rural Doctors
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A/Prof Robert Parker	NT
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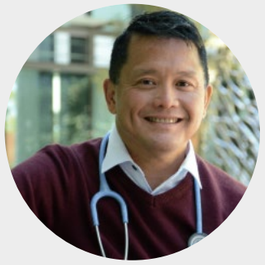
Dr Enis Kocak	VIC
Dr Mark Duncan-Smith	WA
AIDA REPRESENTATIVE	
Dr Tanya Schramm	
AMSA REPRESENTATIVE	
Ms Sophie Keen	
ASMOF REPRESENTATIVE	
Prof Geoffrey Dobb	

AMA LTD BOARD FROM 28 MAY 2021

DR OMAR KHORSHID
President



DR CHRIS MOY
Vice President

A/PROF ROSANNA CAPOLINGUA
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DR STEPHEN GOURLEY
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DR BAVAHUNA MANOHARAN

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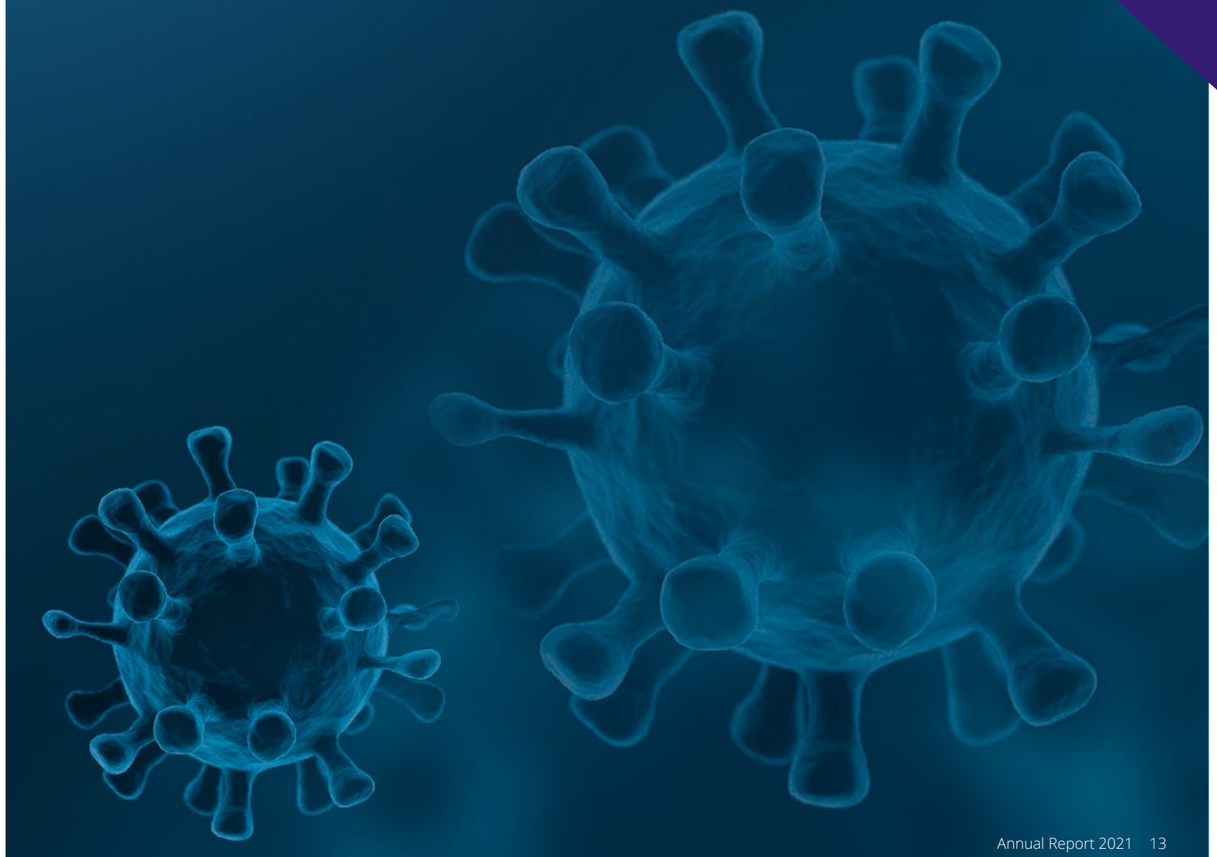
DR RUTH KEARON

COVID-19 RESPONSE REPORT

2021 would be the year COVID vaccines came to Australia. Delivering them would be the biggest public health undertaking in Australian history.



As January dawned, Australians braced for their second year of the pandemic. It would see a shift from managing sporadic outbreaks with only public health measures to vaccinating the country and preparing to live with the virus. Despite many challenges along the way, Australia ended 2021 as one of the most vaccinated countries in the world, with over 91 per cent of Australians aged over 16 being fully vaccinated. Our GPs deserve the highest thanks possible for leading the vaccine rollout and carrying Australia's population through.

Australians were in an enviable position with virtually no COVID-19 cases in the community at the start of the year and the prospect of vaccines soon being available through imports and doses produced domestically through the CSL facility in Victoria. Australia also had a promising vaccine candidate in development by the University of Queensland. The Government made contracts with Pfizer, AstraZeneca, Novavax and the University of Queensland for vaccines for Australia, pending approval by the Therapeutic Goods Administration (TGA). Australia was only the second country to approve a COVID-19 vaccine not under emergency provisions.

The AMA welcomed the country's new Chief Medical Officer, Professor Paul Kelly into the job just before Christmas 2020 and NSW had locked down the Northern Beaches area of Sydney due to a local outbreak. The AMA backed the move and at a time when a zero community-transmission policy was still being pursued, AMA President Dr Omar Khorshid called for the Sydney New Year's Eve fireworks to be cancelled to discourage crowds and avoid confusion over social distancing public messaging.

Planning was underway for the most significant mass-vaccination program of a generation. The AMA worked collaboratively to ensure GPs were at the heart of the program to deliver vaccines to all Australians.

It would be the biggest public health undertaking in Australian history.

AMA Vice President Dr Chris Moy described the planning and logistics involved as being "on the scale of Dunkirk".

While there were missteps in the roll out along the way, the Government and the Department of Health kept working with the AMA to address problems and this helped Australia achieve some of the best vaccination rates in the world.

Initial discussions with the Government and the Department of Health about managing the vaccine rollout focused on the prioritisation of vaccination among the Australian population. Given these vaccines were new, we advocated strongly for a central role for general practice in the vaccine rollout.

The first draft of the plan recognised the central role of general practice but was too constrained, with the Government proposing to roll out the vaccine across 1000 general practices. We made it clear that the strengths of general practice – the trust patients have in their GPs, the connections to community – meant that the rollout should involve all general practices that wanted to participate. The Government listened to the AMA, and as our world-leading vaccination rates at the end of 2021 demonstrated, following the medical advice was the right move.

The AMA also participated in a series of discussions about remuneration for participating GPs. While the final package was not as high as we advocated for, it was significantly more than the initial offering. The AMA continued to advocate successfully over the course of the year for the introduction of additional MBS vaccine consult items.

The AMA also underscored the need for consideration of rurality, after-hours access and the increased complexity of vaccine delivery and equipment supplies to be taken into account.

The AMA worked with the Government to ensure information and consent forms were developed and communicated so that anyone receiving a vaccine gave their full, informed consent. The Department of Health were receptive and consultative throughout this process, and their efforts deserve acknowledgement.

The AMA also encouraged its members to take up expressions of interest from the government to deliver vaccines in their practices.

By February a new 'UK strain' of COVID-19 had breached Australia's practice of quarantining overseas returnees in hotels for a fortnight until they tested negative. The AMA called for tighter measures including smart changes to airflow in facilities and better personal protective equipment (PPE) including N95 masks and eye protection for workers in hotel quarantine.

With the Government's Infection Control Expert Group (ICEG) still downplaying the risk of airborne transmission even while the AMA had been calling it out, Dr Khorshid said the IECG had failed in its duties, allowing more than six months to elapse without a promised review of guidelines to protect healthcare workers from airborne transmission.

In mid-February the AMA welcomed the TGA's approval of the AstraZeneca vaccine as a step towards a safe, timely vaccine rollout. Being produced domestically, AstraZeneca was touted as the vaccine most Australians would receive.

The 22nd of March was announced as the start date for the first vaccines to be administered in Australia with vulnerable groups including the elderly first in line and over 1,000 GPs delivering the vaccine from day one. More than 4,500 accredited general practices were on board to vaccinate staggered groups of eligible Australians.

The vaccine rollout had a slow start, with supply problems plaguing the early parts of the roll out. This delayed the initial rollout and meant that many GPs were provided with fewer doses than anticipated.

The AMA called for temporary telehealth arrangements, due to end in March, to be extended until the end of the year to end uncertainty for GPs wanting to plan for coming months. Telehealth arrangements under Medicare supported patients in having safe, contact-free consultations with their GPs by phone or video. Responding only partly, the government extended temporary arrangements until June, prompting Dr Khorshid to repeat his call in April for an extension to the end of the year. That extension arrived at the end of April and was welcomed by AMA. On 13 December, after years of AMA advocacy, the government announced it would permanently fund telehealth though Medicare with a guarantee for both GP and non-GP specialist services. The AMA said the health of all Australian would benefit from the added layer of convenience and safety for patients and GPs alike.

By the end of March it was becoming clear vaccine demand far outstripped supply and federal and state governments engaged in a 'blame game' over supply and delivery. The AMA called for an end to the squabbling and for transparency to avoid diminishing public confidence in the roll-out.

External problems began to emerge. The University of Queensland trial was abandoned when recipients of the vaccines were recording false positives for HIV. The discovery of Thrombosis with Thrombocytopenia Syndrome (TTS) or vaccine induced thrombotic thrombocytopenia in people who had received the AstraZeneca vaccine also complicated Australia's rollout as this had been intended to constitute the majority of Australia's vaccines. This was not helped by media coverage of TTS that was at times alarmist.

The role of GPs became even more crucial, making sure vaccines went to the most vulnerable and dealing with patient concerns over the AstraZeneca vaccine. The AMA gave voice to GP concerns about the manner in which ATAGI communicated changes to its advice in response to TTS. The speed at which advice was updated and then communicated left many practices working around the clock to manage increasingly scared, confused and at times abusive patients, all the while working to vaccinate as many people as possible.

'Planning was underway for the most significant mass-vaccination program of a generation. The AMA worked collaboratively to ensure GPs were at the heart of the program to deliver vaccines to all Australians.'

Although global incidence was extremely rare, as highlighted by the AMA, the fear of TTS caused many Australians to wait for the Pfizer vaccine, increasing pressure on supplies. The AMA called on the government to urgently explore the availability of alternative vaccines.

Despite these challenges, GPs helped their patients understand risks, proactively engaged their vulnerable patients, convinced many hesitant patients to be vaccinated, all while considering the broader risks based on their existing health conditions. No other health professionals could have performed this role. GPs are the reason why Australia reached such high rates of vaccination.

The AMA made repeated calls for better government communication on vaccines and issued four key actions to build vaccine confidence following Dr Khorshid's presentation to national cabinet on the 12th April:

- improve vaccine distribution to GPs to meet increased demand from people aged over 50.
- adjust Medicare items for GPs to discuss vaccine risks and benefits with their patients.
- better communication of vaccine benefits to individuals and the whole community especially protection for the vulnerable and groups not yet eligible to receive vaccines.
- enable a greater role for states and territories to administer Pfizer, including healthcare workers consideration of GPs role.

With the first stage, 1a, of the rollout underway for some time, the AMA said it was unacceptable there were still unvaccinated doctors and nurses in public hospitals caring for COVID-19 and potential COVID-19 patients. The AMA also advocated for rural doctors, some of whom were still struggling to access vaccinations for themselves, working hundreds of kilometres from vaccination hubs.

In mid-May the AMA Federal Council issued a communique on COVID-19 and future quarantine arrangements, calling for stronger national measures to improve hotel quarantine and for the establishment of long-term dedicated quarantine facilities to manage the ongoing risks of COVID-19, as well as more support for hospitals to meet increased demand and ensure a surge capacity for future outbreaks.

The AMA and the Council of Presidents of Medical Colleges together promoted the benefits of vaccination as far outweighing any health risks and urged Australians to get vaccinated when their turn arrived.

By June the AMA was concerned healthcare workers in aged care – part of phase 1a of the rollout – were still unvaccinated and called for a June 30 deadline for completion of first phase. The AMA supported mandatory vaccination for aged care workers which the government was grappling with and took to national cabinet.

ATAGI recommended Pfizer as the preferred vaccine in adults under the age of 60 in mid-June, again poorly communicated to general practices. Towards the end of that month, a new strain of COVID-19 known as Delta took hold and four Sydney local government areas were locked down. The AMA said a stronger response was required to contain Delta and called for the immediate lockdown of metropolitan Sydney.

AMA advocacy contributed to the welcome measure in June of new Medicare funding for GPs to vaccinate patients during home visits and visits to aged care facilities. Later that month more funding was allocated for longer GP consultations to inform patients of the benefits of vaccination, something the AMA had been advocating for. Again, the Government listened to the medical advice, the AMA relaying the experiences of GPs managing vaccine hesitant patients in their communities.

With TTS came concerns about indemnity. The AMA had called repeatedly for a no-fault indemnity scheme in advance of the commencement of the vaccine rollout to reassure doctors and other vaccinators that they would be protected if they participated in the program and that their indemnity premiums would not increase. The AMA warned that many GPs would be hesitant to vaccinate particular populations, which occurred after the changes to ATAGI's guidance.

After much lobbying, a scheme was implemented in September, six months after the rollout began. This provided more confidence for GPs to administer vaccines and for patients to know they were backed by the government in the event of mishap.

By early July almost half of Australia's population and most major cities were locked down as the Delta strain became a game changer for Australia and public health restrictions. Case numbers rose from single digits in the early days of July to hundreds of daily cases by the end of the month.

To get on top of the Delta outbreak, the AMA called for consistent rules on travel limits and mask wearing throughout Greater Sydney, not just in eight affected Local Government Areas.

At the end of August with several deaths per day from COVID-19, the AMA called for mandatory vaccinations across the entire health care system including support staff like cleaners, receptionists and contractors.

By the end of September, Australia's 1st dose vaccination rate was 77 per cent and 54 per cent were fully vaccinated. Governments were moving away from lockdowns and looking towards lifting restrictions.

The AMA warned hospitals would be overwhelmed and called for new modelling based on hospital and staffing capacity to guide opening-up plans for Australia. A few days later the AMA called out the NSW Government's plan to reopen from lockdown for lacking sufficient detail including modelling of future case numbers and health system impacts.

Later in September, AMA's Federal Council released a statement on the National Plan to transition Australia's National COVID-19 response. It called for a gradual reopening with pause periods to assess and control new infections. It additionally called for:

- equitable access to vaccines,
- a review and update to the Doherty modelling upon which the plan was based,
- the adoption of nationally consistent public health orders that mandate COVID-19 vaccinations for all health care workers and extend legal protection to employers that wish to mandate vaccination for their own workforces.

Appearing before the Senate Select Committee on COVID-19 on 21 September, Dr Khorshid called for an end to public hospital funding blame game by state and federal governments and warned lifting lockdown restrictions must not destroy the health system. He said one-off funding boosts would not address the problems, and neither would one-off initiatives like elective surgery blitzes. He said long-term targeted investment by all governments shared equally were needed.

By late October with the TGA approving Pfizer for the third or booster COVID-19 vaccine for over 18s, the AMA called for a review of funding arrangements for GPs administering COVID-19 vaccines as the government looked to roll out the booster program.

In November another new variant, dubbed Omicron, was detected circulating a pandemic-weary global population. Public health measures were easing around Australia and hotel quarantine arrangements were being dismantled. The AMA warned the resurgence of COVID-19 in many nations was a timely reminder the pandemic was not over and called for a more vigorous rollout of booster shots and a dedicated network of national quarantine facilities.

In December, the AMA sounded a warning Australia's booster program was falling behind, risking more suffering from COVID-19. It expressed concern at a lack of support for the booster program, particularly through General Practice. The Commonwealth cut vaccination funding for GPs delivering boosters, making it difficult to run clinics at the volume and scale required. Continued pressure from the AMA saw the funding restored just before Christmas.

The AMA foresaw DIY contact tracing, watered-down check in requirements, the abandonment of mask wearing mandates, and the removal of density limits converging to a recipe for disaster with hospital admissions and ICU cases growing beyond benchmarks.

'GPs are the reason why Australia reached such high rates of vaccination.'

As Australia prepared to celebrate the new year, national cabinet adopted a new definition of 'close contact', narrowing its scope to household contacts only. The AMA said the decision appeared to put politics over health and would lock in very high transmission rates and accelerate the outbreak of Omicron.

In 2020 and 2021, we saw that Australia was strongest when our leaders listened to medical and scientific expertise. As we enter the third year of the pandemic, the AMA will ensure that this voice remains loud and present, recognising that COVID-19 continues to evolve and Australia needs to remain ready to respond to future threats.

The year came to a close with Omicron surpassing Delta globally and daily cases in Australia rising to more than 30,000 on December 31.

In 2021, 1,331 Australians had died from COVID 19 with 2,239 COVID deaths over the course of the pandemic and a total number of 395,504 cases was recorded on 31 December 2021.

The surging cases were creating significant pressure on the health system, just as the AMA had warned they would.

Australia ended the year as one of the most vaccinated countries in the world, despite the early challenges encountered in the vaccination program.

ADVOCACY HIGHLIGHTS

2021 was a packed year with AMA focused on a range of areas in addition to COVID-19. Our sought-after expertise and tireless advocacy continued to shape and improve the health care sector, the working lives of doctors and the health of all Australians. Here we highlight a few of our major achievements.

COVID-19 VACCINE NO FAULT INDEMNITY SCHEME

One of the key wins for the AMA and its members in 2021 was the establishment of a no-fault indemnity scheme for vaccinators participating in the COVID-19 vaccine rollout. Like many of the AMA's advocacy achievements during the vaccine rollout – such as the extended vaccine consult MBS Item – the process was lengthy and at times seemed likely to fail. Despite clear objections from the Minister and the Department of Health, the AMA persisted and a retroactive no-fault indemnity scheme was formally announced by Health Minister Greg Hunt on 28 August.

The AMA initially called for a no-fault indemnity scheme ahead of the commencement of the vaccine rollout to reassure doctors and other vaccinators that they would be protected if they participated in the program and that their indemnity premiums would not increase.

The AMA warned that many GPs might be hesitant to vaccinate particular populations, which occurred after the changes to ATAGI's guidance on AstraZeneca. A no-fault scheme may have seen more GPs vaccinating with AstraZeneca in Phase 1b and 2a.

There was clear hesitation from the Government and the Department of Health, with the Health Minister responding to AMA concerns in April by saying doctors were already protected. While it is true doctors were protected, the scheme was flawed and did not protect doctors from difficult legal processes, nor address the issue of potentially increasing insurance premiums.

The AMA continued to work to ensure that a true 'no-fault' scheme was introduced. The AMA coordinated medical defence organisations and the business sector (including the Australian Chamber of Commerce and Industry) in putting forward the no fault scheme to Government.

On 28 June, National Cabinet finally agreed with the AMA's proposal, announcing support for a no-fault indemnity scheme. The AMA's position, that the scheme had to cover all vaccines administered to all age groups and be applied retrospectively, would be introduced in Australia. The message was that in the extremely rare case of serious side effects, a patient can access compensation without having to resort to expensive and complex litigation, with doctors needing only to provide evidence.

The AMA continued to work with the Government and the Department of Health, along with other key stakeholders including the medical defence organisations, over the following months to support the development of an effective scheme that would be supported by doctors and patients.

As GPs continue to administer COVID-19 vaccines, now mostly booster doses, the no-fault scheme continues in place ensuring that health care workers involved in the vaccine rollout are not put through distressing court processes for simply playing their role in administering lifesaving vaccines as part of Australia's pandemic response.

AGED CARE REFORM

The Royal Commission into Aged Care Quality and Safety handed down its long-awaited Final Report on 1 March after two years of hearings, thousands of submissions by affected older people and their families and a mass of independent research and reports. In May 2021, in its Budget 2021-22 announcement, the Government provided its response to the Royal Commission's recommendations.

Over the two years of the Royal Commission's work, the AMA provided seven submissions, with the AMA President appearing before the Commissioners three times. Key AMA asks to the Royal Commission included mandatory minimum staff to resident ratios in nursing homes, registered nurse availability 24/7, minimum qualifications for personal care attendants, increasing home care package availability, and increases in MBS rebates for GPs who visit aged care.

The Commissioners heard and supported most of the AMA calls. They recommended, and the Government accepted, that from October 2023, providers will be required to meet a mandatory care time standard of an average 200 minutes for each resident, including 40 minutes of RN time, with nursing homes required to have a nurse on site for a minimum of 16 hours per day. This is below what the AMA called for, but it is a step in the right direction.

In response to the Royal Commission's recommendations, the Government provided an immediate Investment to into home care packages with extra $6.5 billion to fund 80,000 packages. The Government also accepted the recommendation pertaining to minimum qualifications for personal care attendants. All of these recommendations and actions are in line with AMA advocacy.

Finally, the Government provided $365.7 million over four years on improving access to Primary Care and other health services, including $42.8 million to boost the Aged Care Access Incentive from 1 July 2021 to increase support for face-to-face servicing by GPs in nursing homes, effectively doubling the maximum yearly payment to GPs to $10,000. While positive, the AMA remains unconvinced that this measure alone will be enough to incentivise more GPs to work in aged care and will continue to advocate for more funding.

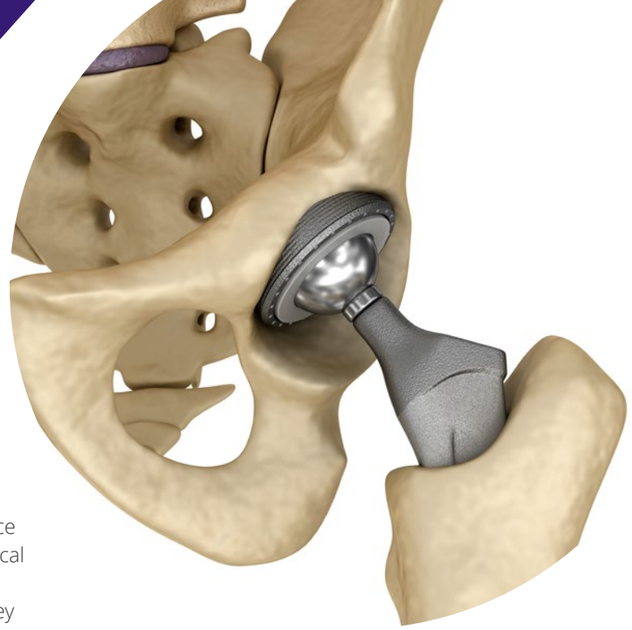
One area where the AMA disagreed with the Royal Commission was the restriction of prescription of antipsychotics to psychiatrists only. The AMA advocated strongly to the Pharmaceutical Benefits Advisory Committee (PBAC), pushing for a sensible approach, maintaining prescribing rights with GPs. PBAC agreed with the AMA, advising the Government against limiting the prescribing.

Following the Royal Commission's recommendations and pre-empting the Government's response, the AMA published a unique research paper on 12 April titled *Putting health care back into aged care*. The paper summarises key AMA policy positions and provides cost-benefit analysis of their implementation. It found that $21.2 billion could be saved from avoidable public and private hospital admissions, presentations and stays from older people in the community and in nursing homes through better provision of primary care. This includes improving access to the older person's usual doctor, and availability of registered nurses on site 24/7.

Being aware that some of the actions taken by the Government in response to the Royal Commission's recommendations do not go far enough, the AMA will continue to advocate for improvements. We will continue to call for a 24/7 nurse presence in nursing homes to avoid potential ongoing failures in care and transfers of both patients and the costs to already overwhelmed hospitals.

Top of the AMA's advocacy platform remains improved funding for GPs working in aged care. GPs are the cornerstone of our health system and people living in nursing homes should have equitable access. Current funding is not conducive to GPs continuing to care for their patients once they enter aged care. This needs to improve and the AMA will continue to advocate for a funding increase to adequately compensate for the complex work done by GPs caring for their elderly patients.

PROTHESES LIST REFORM



In December 2020 the Government announced proposals to reform the Prostheses List, which would have fundamentally changed the nature and management of protheses in the private sector.

The Prostheses List (the List) underpins private practice in much the same way that the MBS and Pharmaceutical Benefits Scheme do. It sets out which medical devices health funds must pay benefits for, and how much they must pay.

For instance, if a member of a health fund has hospital orthopaedic cover and requires a hip replacement, their health fund would be required to pay the minimum benefit for any artificial hip on the List. This means that currently our patients are not subjected to additional out of pocket costs to procure the best prostheses for their condition.

There are more than 11,000 items on the List giving specialists a wide range of choice. Examples of products include:

- hip, knee or shoulder joint replacement devices
- cardiac implantable electronic devices, like pacemakers and implantable cardioverter defibrillators
- vascular and cardiac stents
- human tissue items, like bone or bone fragments, vascular grafts, corneas and heart valves
- insulin infusion pumps.

The AMA agreed that the List delivers well against a range of key criteria including:

- supporting the clinical choice of prosthesis by the medical practitioner, to ensure that the best prosthetic product is used for any particular patient
- providing for the medical device companies to support Australian specialists in their use of specific prostheses
- providing access to a full range of prosthetic items to suit patients' different clinical needs
- ensuring that patients do not have out of pocket costs for a prosthetic item regardless of its expense.

The current arrangements do not support efficient pricing which impacts on the viability of private health insurance going forward.

The Government put forward two models, but the AMA firmly rejected the proposal to introduce a Diagnosis-Related Groups (DRG) bundled funding model that was being strongly pursued by private health insurers. We worked with other key stakeholders such as private hospitals, device manufacturers and consumer organisations to highlight that, whilst the DRG model would improve the bottom line for health funds, it was fraught with danger for patients. It would have meant a reduced choice of prostheses, increased out of pocket expenses for patients, and an increased likelihood of poorer health outcomes.

In the 2021-2022 Budget the Government supported the arguments put forward by the AMA and opted for the retention of a reformed and modernised List moving to the introduction of reference pricing, using the prices paid by Australian public hospitals as a guide.

Whilst this was a major win for the AMA, it is not the end of the story. The reforms announced by Government will extend for four years and completely revamp the structure and clinical logic of the List. This work is already underway and in recognition of the AMA's standing and impartiality in this area, Dr Omar Khorshid was appointed as the Chair of the Clinical Implementation Reference Group.

The AMA will continue to work with Government and stakeholders in this area to ensure the outcomes at the end of this set of reforms deliver savings to private health insurers but without impacting negatively on clinical practice, patient or out of pocket costs.

BONDED MEDICAL PROGRAM ADVOCACY

Since early 2021, the AMA has been meeting regularly with the Department of Health (DoH) Bonded Medical Program (BMP) Executive Team responsible for remediating the range of Bonded Medical Scheme difficulties arising as part of a cohort of bonded participants being incorrectly opted-in to the reformed program. The AMA and AMA member bonded scheme participants also attend a DoH convened stakeholder Implementation Reform Working Group (IRWG).

AMA advocacy and engagement has been instrumental in achieving substantial changes necessary to address the myriad problems which have hampered the program's reputation and angered and inconvenienced doctors, including, participant's practical inability to comply with their obligations and the detrimental impact on their mental wellbeing.

We are now seeing improved outcomes. The development of good collaborative working relationships with the DoH has led to major positive changes for BMP participants as a result.

Key wins the AMA has been able to secure on behalf of participants during this process include:

- no disadvantage for the following cohorts impacted as a result of the issues that arose during the implementation of the program in 2020. These cohorts are:
  - those who thought they were opted in, had completed their obligations and had exited the program
  - those who thought they had opted in and still need to complete their return of service obligations (RoSO); and
  - those who had expressed their interest to opt in via email and were awaiting a DoH response.
- changes to legislation to streamline the process for waiving breaches for Medical Rural Bonded Scholarship participants.
- transparency via public reporting on progress to opt in impacted participants
- regular webinars to provide information to participants on remediation processes and supports
- improved call centre responsiveness and additional training for call centre staff
- revised website to improve access to and availability of information.

The AMA has been pleased that our insistence for more resources being allocated to the BMP has delivered genuine improvement in DoH service and responsiveness to participants; but we do recognise many frustrations and challenges remain.

As a result of ongoing AMA advocacy to implement reforms to the BMP, new legislation is in place that streamlines the process for waiving breaches for the Medical Rural Bonded Scholarship. Also, changes will allow the DoH to opt in participants more quickly and to identify cohorts that can be opted in now so that they can move on with their careers, i.e those whose return of service is complete and can exit the program.

The AMA will continue to provide updates to those AMA members on the BMP and to report on progress to achieve our agenda. AMA Member feedback is welcome via email: workforce@ama.com.au

CLIMATE CHANGE ADVOCACY

The health sector is a big emitter of CO2, contributing to approximately seven per cent of Australia's national carbon footprint. A partnership with Doctors for the Environment Australia (DEA) formed in March called on the health sector to reduce its carbon emissions to net zero by 2040, with an interim target of 80 percent by 2030.

The AMA had declared climate change a health emergency, recognising that setting clear emission-reduction targets was a fundamental step towards measurable and tangible change. The AMA and DEA recommended the establishment of a national sustainable healthcare unit to support emissions reduction across the health care system, as well as the uptake of low carbon procurement options across the medical supply chain and hospitals.

In July 2021, the AMA expressed disappointment at the majority decision of the Standing Committee on Environment and Energy to recommend against passing new proposed climate change bills. The AMA had previously supported the draft legislation put forward by Independent MP Zali Steggall, acknowledging that Australia needed a clear pathway to limit global warming to 1.5°C to mitigate the known impacts of a warming climate.

In August the AMA called on the government to act on the scientific evidence outlined in the 2021 Intergovernmental Panel on Climate Change report, noting that large scale reductions in carbon emissions were urgently required to halt any further rise in global warming. The calls coincided with devastating fires and floods across Europe and North America in the 2021 northern hemisphere Summer.

AMA and DEA hosted a September webinar with medical and climate experts, focusing on what role the health sector can play in reducing carbon emissions. This webinar garnered the attendance of most medical specialist colleges represented by their Presidents and CEOs and outlined the work underway across their sectors to decarbonise work practices and advocate for climate change as a health issue.

The AMA President jointly co-authored an MJA Insight article with Dr Kate Charlesworth to articulate the discussion and outcomes arising from this meeting of over 350 doctors. The group penned an open letter to the Prime Minister ahead of the COP26 climate conference in Glasgow, calling on the government to take meaningful steps towards net zero emissions.

Just ahead of COP26, the Australian government released its plan to achieve net zero emissions by 2050, which the AMA cautiously welcomed, noting its success would need to be ensured through meaningful regulatory and economic reforms.

The 2021 webinar established an important discourse across the medical sector around decarbonising health care. The substantial engagement of specialist medical colleges illustrated the importance of leading a health sector response towards net zero, something the AMA and DEA will continue to facilitate in 2022 under our Memorandum of Understanding.

PRIORITISING CHILD HEALTH

The AMA convened a Child Health Summit on 16 November bringing together experts in child health and welfare to put child health and wellbeing at the centre of public policy making. Attending were Royal Australasian College of Physicians (RACP), Australian Council of Social Service (ACOSS), Murdoch Children's Research Institute (MCRI), Academy of Child and Adolescent Health and Australian Research Alliance for Children and Health (ARACY). The summit released a communique calling on a newly formed government (after the 2022 Federal election) to establish a Child Health Taskforce to report within six months on priority initiatives to improve the social determinants of health.

The summit considered child health and wellbeing in the context of the impacts of the COVID-19 pandemic, as well as broader social, economic and equity issues that have persistently impacted health outcomes.

During the pandemic, governments demonstrated that public policy could be swift and responsive to meet specific objectives. This includes the raft of public health measures that were implemented to mitigate the spread of COVID-19, as well as the additional welfare supports that were provided through JobSeeker payments to people who could not work during lockdowns. The AMA and attendees at the child health summit agreed on the need for a similar level of targeted policy response to ensure all Australian children were given opportunities to be in good health, feel safe, receive an education and envision a future for themselves.

Participants at the summit recognised that climate change required an urgent response from today's leaders to protect the health and wellbeing of current and future generations. Health and environment are inextricably linked, and it was imperative to ensure a livable environment for children in the years to come. Australia urgently needs a path to transition away from fossil fuel-based energy, towards renewable sources in order to meet net zero targets.

Social determinants of health impact on children's lives. Accordingly – the communique focused on specific calls to government:

- to reduce poverty. Stating our responsibility to ensure all households can meet basic needs such as food, heating and shelter. Government must ensure welfare and income support payments are in line with the increasing costs of living
- on housing. Access to safe and secure housing is a fundamental human right and essential for child health and wellbeing
- on nutrition and food security. Children who are hungry or under-nourished are more susceptible to developmental delays, poor health outcomes and poor education outcomes.

Reform of the processes that improve the mental health and wellbeing of children has been increasingly needed in recent years. We need a mental health workforce that is trained to deliver mental health care for children and young people, and a system that is responsive, accessible and affordable. The impacts of the pandemic on upending the lives of young people, has only intensified this need. The summit also called on the government to fund and implement the recommendations in the National Children's Mental Health and Wellbeing Strategy (2021).

AMA ADVOCACY

The AMA has advanced many other issues on behalf of AMA members. Here are some of our key wins in 2021.

2021 KEY WINS

FOR GPS

COVID-19

Significant advocacy was required for the COVID-19 vaccine rollout with the AMA winning a number of outcomes for GPs who were to take part.

The Government's plan was originally to restrict the vaccine program to just 1000 practices. Through intense negotiations, as a result of AMA advocacy, the original plan was reversed and any general practice which met the National Immunisation Program requirements could participate and provide COVID-19 Vaccinations to their patients and the community.

With an unsatisfactory remuneration package on the table, AMA fought for those providing COVID-19 vaccination services. The remuneration package was improved with higher rebate for Dose 1 and PIP payment for completion of Dose 2.

MBS flagfall items were later introduced to support GPs providing vaccinations to patients at home or in residential aged care facilities.

AMA lobbying also secured a Vaccine Counselling item equivalent to a Level B to counsel targeted patients about the risks and benefits following ATAGI advice changing on administering the AstraZeneca vaccine.

The AMA also convinced the Commonwealth to establish a special COVID-19 vaccine indemnity scheme for GPs and vaccine providers. The Scheme offers protection to individuals who receive a TGA approved COVID-19 vaccine, irrespective of where that vaccination occurs and cover the costs of injuries above $5,000 due to proven adverse reaction to a COVID-19 vaccination. (See detail in Advocacy Highlights.)

Aged Care

In aged care current settings meant poor remuneration and inadequate incentives to support the time and opportunity costs of providing GP care to Residential Aged Care Facilities. AMA won additional tiers of service to the Aged Care Access Incentive, doubling the total amount payable. Better supports won will encourage GPs to make nursing home visits.

Primary Health Reform

Continuing advice and AMA policy was accepted by the Government for primary health reform and reflected in the Recommendations of the Primary Health Reform Steering Group. This resulted in the Government's 10 Year plan including support for voluntary enrolment, enhancing multidisciplinary care, enabling connected care, and funding reform.

RURAL

The AMA considered remuneration for rural supervisors inadequate and worked hard to ensure Doctors are better supported to train doctors in training and medical students in rural areas. Our advocacy saw the implementation of supervision support payments up to $30,000 and learning and development funds up to $13,600 per annum per More Doctors for Rural Australia Program participants.

Work to reform the Bonded Medical Program resulted in a no disadvantage guarantee for all affected Bonded Medical Places Program and Medical Rural Bonded Scholarship opt-in participants impacted by administrative problems in the transition to the more flexible Bonded Medical Program.

The AMA worked to improve insufficient prevocational general practice training placements in 2021 and secured the expansion of funded prevocational general practice training placements in rural areas, from 440 rotations per year to 800 by 2025. As a result, there are now greater opportunities for doctors in training to get experience and an understanding of working general practice.

MENTAL HEALTH

With extended COVID-19 lockdowns increasing mental health issues in the community in 2021, mental health reform was on the agenda. The AMA contributed by influencing policy through submissions to:

- Final Productivity Commission Inquiry Report on Mental Health
- Senate Select Committee on Mental Health and Suicide Prevention
- Draft Mental Health Workforce Strategy
- Draft Initial Assessment and Referral Tools for Child and Adolescent Health

Dr Omar Khorshid and Dr Danielle McMullen also appeared before the Select Committee on Mental Health and Suicide Prevention to give evidence to support the AMA written submission.

Dr Khorshid published a Guardian opinion piece regarding the impacts of Covid on the mental health of young people and the AMA call to reduce fragmentation of care across the mental health system.

2021 was an opportunity for the AMA to present comprehensive feedback to the government on what we believe needs to happen to reform the mental health care system:

- More support for GPs to offer comprehensive mental health care
- Urgent addressing of psychiatrist workforce shortage
- Reducing demand on Emergency Departments to provide acute mental health care

PROSTHESES LIST

Following a consultation that included the possibility of removing the Prostheses List and moving to bundled payments (which could have restricted doctor choice and caused new out of pocket costs for patients), the 2021-22 Federal Budget announced an investment of $22 million over four years to improve the Prostheses List and its arrangements and deliver $900 million in savings.

This was a significant hard-fought win by the AMA for patients and doctors alike. Working with private hospitals, medical device manufacturers and consumer organisations to ensure the Prostheses List was retained and that changes would not impact negatively on patients. Clinicians can still choose the right device for their patients, based on their clinical needs while improving value in private health insurance (PHI).

As a result, patients will not be subject to an additional out of pocket cost for prostheses. Doctors will retain their ability to choose the prosthesis they believe is the right choice for them and their patient.

PHI premiums will be lower than they otherwise would which will give more Australians access to the PHI system. (See detail in Advocacy Highlights.)

PUBLIC HEALTH

LGBTQIA+ Position statement

The AMA released a LGBTQIA+ position statement in November. This substantially advanced the AMA's policy position on gender identity and sexual diversity, including policy recommendations for equitable health care for trans people and those with an intersex variation.

This updated position statement received the praise of external peak organisations and endorsement by the expert advisory group. The updated advice has supported AMA responses to current LGBTQIA+ health issues.

Climate change action

The AMA and Doctors for the Environment convened a high-profile event via webinar attended by the ten specialist medical colleges, with the AMA and DEA showing leadership across the medical sector with excellent engagement from medical colleges. Dr Nick Watts also presented the NHS model from the UK – outlining the effectiveness of a sustainable health unit in reducing emissions across the hospital system. (See detail in Advocacy Highlights.)

Child health summit

The AMA convened a summit with child health and welfare expert groups to map out shared priorities to take to the election and beyond around child health. A communique from the group cited poverty, climate change, mental health and food security as some of the key issues requiring urgent attention. (See detail in Advocacy Highlights.)

INTRODUCTION OF E-PRESCRIBING

Under the Government's plan for expansion of e-prescribing, medical practitioners were expected to bear part of the cost of prescriptions sent to patients via SMS. The AMA advocated strongly with the Department of Health to ensure that practices did not have to pick up the SMS costs associated with e-scripts.

Following the AMA advocacy, the Federal Government introduced a subsidy that has allowed practices to prescribe via SMS without incurring additional costs. The subsidy is expected to last at least until June 2022.

AMA advocacy also ensured that the temporary image based prescribing measures were extended twice during 2021 to allow doctors to continue to prescribe safely during the pandemic.

MEDICARE

Implementation of Medicare changes arising from the Medicare Benefit Schedule reviews.

The 1 July MBS changes made national headlines and dominated the media, following an AMA media release on 6 June, outlining concerns that patients and practitioners do not have the information they need to be ready for the significant changes to orthopaedic, cardiac and general surgery services listed on the MBS.

In response to the media and public reaction, the Government agreed to three significant asks AMA has advocated for in recent years

1. a rapid process to review some of the oversights and errors or unintended consequences that are there buried within the review recommendations
2. to work together to co-design the administrative processes that support implementation of future changes to the MBS to ensure all parts of the system are ready
3. change to have private health insurer rebates monitored by Government, and for the first time, published on the Government's fees website.

AMA advocacy has led to improvements on how Medicare changes are implemented and communicated to medical practitioners and the public.

Telehealth Items

A temporary extension of Telehealth items until 31 December was subsequently made permanent after years of AMA advocacy. GPs and non-GP Specialists can now continue providing consultations by Telehealth. Phone items are retained but limited.

IMPROVED PPE GUIDELINES TO PROTECT DOCTORS FROM COVID-19

The AMA advocated ceaselessly throughout the pandemic to ensure that personal protective equipment (PPE) guidelines were strengthened so all doctors and health care workers were wearing appropriate PPE that would protect them from COVID-19. The AMA wrote to the Chair of the Infection Control Expert Group (ICEG), discussed it in media appearances, and Dr Khorshid outlined the AMA's concerns to the Senate Select Committee on COVID-19.

In response to this advocacy, ICEG collaborated with the National COVID-19 Clinical Evidence Taskforce Infection Prevention and Control Panel to develop updated guidelines on the use of PPE to protect health care workers against aerosol transmission of COVID-19.

The updated guidelines released on 10 June were much more explicit on the need for health care workers to be provided with N95/P2 masks when managing patients with confirmed or suspected COVID-19 to protect them against the risks of aerosol transmission.

MEDICINE SCHEDULING

Vaping and the oral contraceptive pill

Nicotine vaping products (NVPs) were made schedule 4 (prescription only), closing loopholes to access and further restricting access to nicotine vaping products. The AMA continues to advocate for strengthening these regulations. The AMA's priority remains to reduce smoking and vaping use in Australia.

AMA advocacy has ensured that Australia maintains strong tobacco control measures, as well as ensuring that GPs remain central to quitting smoking.

Strong and sensible AMA advocacy saw another attempt to downshcedule the oral contraceptive pill to schedule 3 (pharmacist only) prevented. The AMA lodged a submission to the TGA's consultation on the Proposed amendments to the Poisons Standard, with two proposals being presented to down schedule oral contraceptive pills.

The AMA submission contributed to the decision not to downschedule the oral contraceptive pill. This would have had a detrimental impact on public health by fragmenting care and excluding the patient's usual GP. It would have also removed opportunistic care provided by GPs, risking other health conditions not being detected by a pharmacist.

MEDICINE SHORTAGES

Ensuring prescriber decisions are honoured during medicines shortages

The AMA has met often with the TGA during the pandemic, working to support the development of the Serious Scarcity Substitution Instrument (SSSI). SSSIs allow pharmacists to substitute a medicine in a shortage for a TGA-determined alternative. AMA advocacy ensured that the initial rules were changed by the TGA so that pharmacists need to have processes in place to notify the prescriber of the substitution, to ensure pharmacists honour the 'do not substitute' request from prescribers even if the medicine is under an SSSI, and to ensure that pharmacists cannot substitute if they have access to the scarce medicine.

AMA advocacy has ensured that the prescribing doctors have the final say on what medicines are dispensed to their patients, and that all urgent substitutions must be made with their input.

AMA LIST OF MEDICAL SERVICES: FEES LIST

Review of non-AMA member licencing arrangements

The AMA undertook an external review of the Fees List licencing arrangements for non-AMA members in 2021.

The review resulted in an updated licencing arrangement to account for the various categories of non-traditional users of the AMA Fees List (eg State and Federal worker's compensation schemes and State Health Departments).

The new AMA Fees List licencing arrangements ensures that it continues to be used by a wide range and number of AMA members, non-members and other organisations. This assists to ensure that medical practitioners are adequately remunerated for medical services that they provide, and that the Fees List remains an influential advocacy tool on behalf of members.

PROFESSIONAL SERVICES REVIEW

Review of procedural fairness of Section 92 agreements

A review was commenced in late 2021 into the procedural fairness of section 92 agreements as part of the Professional Services Review process. This was initially called for by the AMA in 2019.

The AMA wants this process to review issues raised by members in recent years, such as a lack of transparency, lack of clarity of options available to them including appeals, and the PSR not adequately explaining the problem with their billing practices. Ultimately this should improve the profession's faith in the PSR.

DOCTORS IN TRAINING

Flexibility for prevocational doctors to enter specialist training

AMA advocacy has ensured that the Review of the National Framework for Prevocational Medical Training and the proposed two-year framework for prevocational (PGY1 and 2) medical training A) continues to provide PGY2 doctors with the flexibility to enter specialist training, and that B) PGY2 doctors will be exempt from formally reporting on the Medical Board of Australia Continuing Professional Development Registration Standard requirements if in a structured program.

Wins for doctors in training mean A) Prevocational doctors' career choices are enhanced in areas to meet community care needs. B) Reduction in unnecessary reporting and stress for prevocational doctors so they can focus on training and delivering care.

Advocacy for GPs in Training

The AMA Council of Doctors in Training (AMACDT) has established a GPs in Training Advisory Committee which has a seat at the table on the Commonwealth Department of Health GP Training Advisory Committee and Transition to College Led Training Advisory Committee, allowing us to advocate on the things that matter to GPs in training including reforms to parental leave entitlements and improved employment conditions.

Improved employment conditions for GPs in Training is a key action in the National Medical Workforce Strategy (NMWS) and a recommendation in the Senate Inquiry into access to GP in rural and remote communities.

Reviewing the unaccredited service registrar model

AMA advocacy saw the NMWS include an action to review the unaccredited service registrar model for service delivery including determining naming conventions, defining the various groups within this cohort, considering factors that impact on these groups and potential framework/trial parameters.

This will result in a review of unaccredited service Doctors in Training registrar roles to provide a valid and more structured training experience and career pathway.

Progression through training for specialist trainees

The AMACDT has established a range of Special Interest Groups and Advisory Committees, engaging more than 100 doctor in training members in AMA policy development and advocacy.

The AMA worked to secure state and territory jurisdictional exam exemptions for Specialist Medical College exams and paved the way for procedures for College examinations to be progressed within each jurisdictions according to respective COVID safe guidelines.

Engaging with our members

The AMACDT has established a range of Special Interest Groups and Advisory Committees, engaging more than 100 doctor in training members in AMA policy development and advocacy. This will mean more AMA members can have a say in the development of AMA policy and advocacy.

EQUITY, INCLUSION AND DIVERSITY

Report on first AMA Member diversity survey

The AMA conducted its first Member Diversity Survey in December 2020 to better understand the experience and perceptions of our membership in relation to diversity, inclusion, and representation.

Six opportunity areas have been identified for development:

- Transformation of leadership image
- Promotion of a gender equitable culture
- Commitment to advancing women
- Organisational support
- Mentoring and networks
- Leadership development

Our partnership with AWHL and the organisational change management project underway will assist the AMA to increase and support the number of women in representative positions.

Role descriptions for AMA Council & Committee positions

The AMA has developed role descriptions for representative positions, so the level of commitment and responsibilities associated with roles are clear to members. This is available on our website and makes clear to all members skill sets and time commitments when undertaking representative roles.

AMA RESEARCH AND REFORM UNIT

AMA Research and Reform Unit

The AMA has a long history of strong policy expertise and providing advice to government to assist policy decision making.

Recognising the next wave of health policy reform would need to be intertwined with communications and campaigning to gain and maintain political and public traction, the AMA established the Research and Reform Unit in 2021.

Creating a platform for the development and implementation of health policy reform, the AMA Research and Reform Unit works with policy experts to produce evidence-based and implementable solutions to Australian's biggest health challenges, including those not on the political agenda, while working closely with communications and media groups to create stakeholder take-up.

KEY ACHIEVEMENTS IN 2021

Australia's health system is one of the best in the world, however it falls short in several areas, including access to care, prevention, and coordination.

To show where reform is needed, the AMA launched its *Vision for Australia's Health* in June at the National Press Club.

The Vision is a blueprint to secure a robust, sustainable health system into the future and provides a guide to government and policymakers to preserve Australia's standing as a provider of world-class healthcare.

The Vision proposes sensible and targeted initiatives across five pillars: general practice, public hospitals, private health, a health system for all, and a health system for the future.

The research report *Putting health care back into aged care* was released on 13 April, and was the first time financial implications of avoidable hospital admissions from aged care have been quantified.

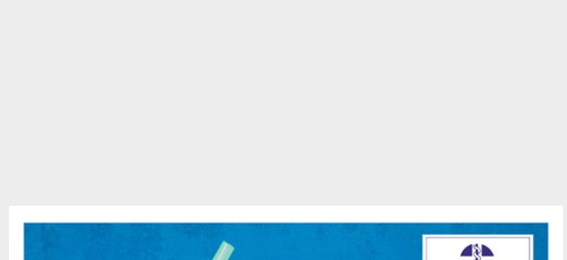
Can we please say "Modelling from the Research and Reform Unit revealed that $21.2 billion could be saved over four years if immediate reforms were implemented to our aged care system to address potentially avoidable admissions to private and public hospitals.

The report provided a platform for the AMA to launch the 'Care Can't Wait' campaign in partnership with the Australian Nursing and Midwifery Federation. The report resulted in several key outcomes, including commitment from Government to:

- Implement a mandatory minimum staff-to-resident ratio and improve availability of registered nurses
- Improve senior Australians' access to primary care
- Greater interoperability between GP clinical and aged care software systems, with the use of My Health Record in aged care
- More home care packages

Working closely with AMA policy experts, this report was built on several years of AMA position statements on healthcare in aged care and called for greater funding to support GPs to work in aged care. The research would inform and be incorporated into 2022 campaigns.

The research report *A tax on sugar-sweetened beverages: Modelled impacts on sugar consumption and government revenue* was launched on 9 June at the National Press Club. The modelling indicates that a tax on select sugary drinks would reduce sugar consumption from soft drinks by 12 to 18 per cent and raise annual government revenue of $749 million to $814 million.



The launch was welcomed in the public sphere with coordinated social media activity from obesity and chronic disease stakeholders. It was also welcomed by AMA members as a key component of AMA's public health advocacy agenda. The research report was translated into a social media campaign – the *#Sickly-Sweet* campaign – in January 2022, educating Australians about the health risks of sugary drinks and the need for a tax on them.

The research report *Public hospitals: Cycle of crisis* was launched on 15 October, and presents a compelling and worrying picture of the future of public hospital performance under a 'do nothing' scenario, with straightforward solutions in the form of a revised and expanded funding model to turn the crisis around. The report is set in the context of COVID-19 pandemic, highlighting that public hospitals were under pressure before the pandemic, and would not have the capacity to scale up to meet the demands of a widespread COVID-19 outbreak or a typical flu season.

Working closely with AMA policy experts, the report was built on the previous work the AMA has done in calling out the declining performance of public hospitals through the annual AMA Public Hospital Report Card. It also took the anecdotal evidence from AMA members to provide a robust account of how chronic underfunding of public hospitals has led to declining performance and jeopardises lives. The research report was recently translated into the AMA *Clear the hospital logjam* campaign, which was launched in February 2022.

AMA AT WORK

Leading Australia's Doctors – Promoting Australia's Health

AMA COUNCILS, COMMITTEES & WORKING GROUPS

Councils

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

Committees

- Ethics & Medico-Legal Committee
- Equity, Inclusion & Diversity Committee
- Public Health Committee
- Fees List
- Funding & Health System Reform Committee
- Digital Health Sub-committee
- Mental Health Committee
- Medical Practice Committee
- Taskforce on Indigenous Health
- Industrial Coordination Meeting

SUBMISSIONS

AMA made the following submissions in 2021:

- AMA submission on opportunities for reform of GP training employment arrangements
- AMA submission to the Evaluation of the DVA's Allied Health Treatment Cycle Arrangements
- AMA Submission - Department of Health Consultation on Aspirations for the Food Regulatory System
- AMA submission on the Draft National Medical Workforce Strategy
- AMA submission to the TGA - proposed amendments to the Poisons Standard - March 2021
- AMA Submission to the Department of Health Consultation in relation to options for further reforms to Private Health Insurance - Age of Dependents
- AMA submission to the Department of Health consultation in relation to options for reforms and improvements to the Prostheses List
- AMA Submission to the Department of Health consultation in realtion to options for further reforms to Private Health Insurance. Consultation 4: Applying greater rigour to certification for hospital admission
- AMA submission to the Inquiry into Australia's skilled migration program
- AMA Submission to the Deaprtment of Health consultation in realtion to options for further reforms to Private Health Insurance. Consultations 2 and 3: Expanding home and community-based rehabilitation and mental health care.
- AMA submission on the Data Availability & Transparency Bill 2020
- AMA Submission to the Podiatry Board of Australia - Draft proposed professional capabilities and accreditation standards for podiatry and podiatric surgery
- AMA Response to Productivity Commission Inquiry Report on Mental Health
- AMA Submission on Revised Registration Standard for Endorsement for Acupuncture for Registered Medical Practitioners
- AMA Submission on definition of general practice for the purpose of accreditation
- AMA submission to the Therapeutic Goods Administration - Standard for vaporiser nicotine
- AMA Submission to the Medical Board of Australia's Confidential Preliminary consultation on a Draft Registration Standard: Health checks for late career doctors (Confidential Consultation)
- AMA submission to the Senate Select Committee on Job Security Inquiry into the impact of insecure and precarious employment
- AMA Submission to the Chief Health Executives Forum - National Registration and Accreditation Scheme for the Health Professions, Consultation on the draft Health Pactitioner Regulation National Law Amendment Bill
- AMA submission on the Draft National Preventive Health Strategy 2021-2030
- AMA Submission to the Senate Inquiry into the Administration of registration and notifications by the Australian Health Practitioner Agency and related entities under the Health Practitioner Regulation National Law
- AMA Submission: Joint Standing Committee on the NDIS - Independent Assessments
- AMA Submission to the Public Consultation on Revised Regulatory Principles for the National Scheme
- AMA Submission to the Preliminary Consultation on the Review of the English Language Skills Registration Standards (Confidential Consultation)
- AMA submission to the Therapeutic Goods Administration - Proposed amendments to the Poisons Standard - June 2021 - oral contraceptives
- AMA submission to the Australian Commission on Safety and Quality in Health Care - National Opioid Analgesic Stewardship Program
- AMA submission to the Therapeutic Goods Administration - Proposed amendments to the Poisons Standard - June 2021
- AMA submission - FSANZ Act Review draft Regulatory Impact Statement
- AMA calls on ACCC to abandon proposed authorisation of Honeysuckle Health/ NIB buying group
- AMA submission to the Therapeutic Goods Administration - Proposed improvements to the Therapeutic Goods Advertising Code
- AMA response to Practice Incentive Program eHealth Incentive (ePIP) Review Discussion Paper
- AMA submission to the Therapeutic Goods Administration - Proposed refinements to the regulation of personalised medical devices
- AMA Submission to the Senate Community Affairs Legislation Committee inquiry into the National Disability Insurance Scheme Amendment (Improving Supports for At Risk Participants) Bill 2021
- AMA Submission in response to Primary Health Reform Steering Group Draft Reccomendations
- AMA Submission in response to Disability Support (DSP) Impairment Tables Review Issues Paper
- Submission to Select Committee on Mental Health and Suicide Prevention
- AMA submission to the Therapeutic Goods Administration - Proposed refinements to the regulation of medical devices that are substances introduced to the human body via body orifice or applied to the skin
- Submission to Palliative Care Australia on Consultation Draft - Standards for Generalist Palliative Care
- AMA Submission to the Private Health Australia exposure draft of Combatting surprise billing in Australia.
- AMA Submission to the Further Review of Quarantine Arrangements
- AMA Submission to the Review of General Practice Accreditation Arrangements
- AMA submission - National Plan on Reducing Violence Against Women and their Children
- AMA Submission to Health Ministers: Addressing health system demand from COVID-19 discussion paper
- AMA submission - National Climate Resilience and Adaption Strategy
- AMA Submission on the Preliminary Ahpra Draft Data Strategy (Confidential Consultation)
- AMA Submission in response to Consultation Paper No 1 Prostheses List - Purpose, Definitions and Scope
- Ama Submission to Inquiry into provision of general practitioner and related primary health services to outer metropolitan, rural, and regional Australians
- AMA Submission to the Independent Hospital Pricing Authority's (IHPA) Consultation Paper on a Methodology for Determining the Benchmark Price for Prostheses in Australian Public Hospitals
- AMA Submission on RACGP Administrative Changes to Standards for General Practice (5th edition)
- AMA submission to Healthcare Management Advisors on the Streamlining and Expansion of RPGP and Procedural PIP
- AMA response to National Mental Health Workforce Strategy Consultation Draft
- AMA Submission to PBAC - Restricted prescription of antipsychotics in residential aged care
- AMA submission to the Medical Services Advisory Committee - Pharmacy Diabetes Screening Trial
- AMA submission to the Therapeutic Goods Administration - Proposed amendments to the Poisons Standard - November 2021
- AMA Submission to Australian Digital Health Agency (ADHA) consultation on the mHealth applications Assessment framework
- AMA submission to the Australian Commission on Safety and Quality in Health Care - updating national Quality Use of Medicines publications
- AMA submission to ANAO on the performance audit of Australia's COVID-19 vaccination rollout
- AMA Submission - Department of Health Consultation on Draft National Obesity Prevention Strategy 2022-2032
- AMA submission on Australia's Primary Health Care 10 Year Plan 2022-2032 consultation Draft
- AMA submission to the Department of Health - National Medicines Policy Review
- AMA response to proposed changes to the RACGP Standards for general practices (5th edition) - COVID 19/IPC
- AMA submission to Health Management Advisors (HMA) – on Consultation Paper 2 – Streamlining and Expansion of the RPGP and PIP Procedural GP payment
- AMA submission to the Australian Academy of Health and Medical Sciences project to improve healthcare for Australians by better enabling research to be conducted within the health system

- AMA submission to Draft National Safety and Quality Health Service Standards user guide for acute and community mental health services
- AMA Submission to Senate Inquiry into Disability Support Pension - re proposed reinstatement of DSP Treating Doctor Report
- AMA Submission to the National Healthcare Interoperability Plan
- AMA Submission to the Therapeutic Goods Administration - mandatory reporting of medical device adverse events by healthcare facilities
- AMA Submission to Professional Services Review - section 92 agreements
- AMA submission to the consultation on new residential aged care design standards
- AMA Submission to Nurse Practitioner 10 Year Plan Consultation Paper
- Submission to Parliamentary Joint Human Rights Committee Inquiry into the Religious Discrimination Bill 2021
- Submission to Senate Standing Committee on Legal and Constitutional Affairs Inquiry into the Religious Discrimination Bill 2021
- AMA Submission to the Department of Health on the Draft Health Practitioner Regulation National Law Amendment Bill

POSITION STATEMENTS

The AMA produced the following positions in 2021:

- Measuring clinical outcomes in general practice 2021
- Health Literacy - 2021
- Position Statement on Advertising and Public Endorsement
- Medical parents and prevocational and vocational training
- General Practitioners in Maternity Care Position Statement
- Ten Minimum Standards for Telemedicine
- General Practice Nurse 2021
- Prevocational medial education and training - 2020
- Fundholding - 2021
- Primary Health Networks 2021
- Integration of General Practitioners into rural hospitals
- AMA Position Statement - Cultural Safety
- Position Statement: Health Savings Account 2021
- Workplace Facilities and Accomodation for Hospital Doctors - 2021
- National Intern Allocation Process - 2021
- The future of dispensing – ensuring Australians have affordable and accessible medicines into the future
- Medicines 2021
- Clinical Indicators 2021
- Out of hours primary care 2021
- Supporting GPs in the Immediate Aftermath of a Natural Disaster 2021
- Vaccinations Outside of General Practice - 2021
- LGBTQIA+ Health - 2021
- Medical Home - 2021
- Workplace Bullying, Discrimination and Harrassment 2021
- Digital Health Vision Satetment Preamble

REPORT CARDS

- Public Hospital Report Card 2021
- Private Health Insurance Report Card 2021

APPEARANCES AND FORUMS

- Public Hearing – select committee on COVID-19 (January 2021)
- Public Hearing - Select Committee on COVID-19 Children and the vaccine rollout)
- Public Hearing – select committee on COVID-19 (April 2021)
- Public Hearing – Select Committee on Mental Health and Suicide Prevention (6 August)
- Public Hearing – Senate Select Committee on Job Security (16 September)
- Senate Committee Public Hearing on Provision of general practitioner and related primary health services to outer metropolitan, rural and regional Australians (3 November)

MEMBERSHIP

The AMA has been reporting on gender diversity since 2019 in line with a commitment to achieving a target of 40 per cent women, 40 per cent men, 20 per cent flexible for all Federal AMA Councils, Committees and Boards, with a gender diversity target of women holding 50 per cent of Federal AMA representative positions overall.

To date the AMA has not met is targets and in December 2021, AMA Federal Council reaffirmed its commitment to achieving its gender targets with a revised time frame for attainment by 2024.

Overall, of 224 representative positions on Federal AMA Councils and Committees as of 31 December 2021, 145 (65%) were held by men, 79 (35%) were held by women. While the target was not met, this is a slight improvement from last year (66%m; 31%f) and a marked improvement since 2018 (74%m; 26%f). Of the 15 Federal AMA Councils and Committees considered in this report, 11 (73%) were chaired by men, 3 (20%) by women and 1 (7%) jointly chaired; noting the Federal Board has a female chair.

Moving forward, our partnership with Advancing Women in Healthcare Leadership and the organisational change management project underway will assist the AMA to increase and support the number of women in representative positions. The AMA has also taken steps to improve diversity in representation as part of its proposal to reform the structure of Federal Council to be approved at a General Meeting in 2022.

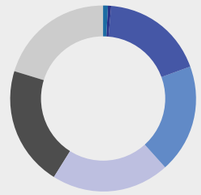
During the year, the AMA engaged the health care research firm Luma to conduct research of both AMA members and non-members to inform the how best to support doctors in their roles. The research among other matters revealed the top ten-member service priorities doctors look to the AMA to provide as being:

- Advice or assistance with a workplace relations issue
- Support, information and advice on a professional or ethical matter
- Billing advice (e.g. AMA fees list)
- First port of call for medico legal advice
- Business learning, support, information and advice to set up or run a private practice
- Leadership/management coaching e.g. to aid career progression
- Peer support: a one-on-one relationship with a peer or more experienced doctor
- Mentoring: a one-on-one relationship with a more experienced doctor
- Discounts on premium products e.g. tech, frequent flyer membership, cars
- Scholarships for young researchers

Membership by gender

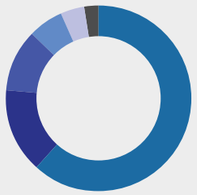
- Female: 38%
- Male: 62%

Membership by age



- NULL: 1.00%
- Under 25: 0.52%
- 25-44: 18.06%
- 35-44: 18.78%
- 45-54: 20.65%
- 55-65: 20.75%
- Over 65: 20.24%

Membership by tenure



- 1-10: 61.89%
- 11-20: 14.53%
- 21-30: 10.91%
- 31-40: 6.25%
- 41-50: 3.94%
- Over 50: 2.48%

Membership by type

- Doctor in Training: 16.38%
- GP, non-GP specialist: 45.94%
- Retired from practice: 2.19%
- Other, academic & administration: 2.13%
- Associate medical student members: 33.36%

MEDIA REPORT

The AMA President, Dr Omar Khorshid and Vice President, Dr Chris Moy emerged as trusted, sought-after sources for media commentary on the pandemic, the health of Australians and many other aspects our health system throughout 2021.

Along with other AMA spokespeople they 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 significantly increased audience of 657, 677, 772 readers, viewers, and listeners.

AMA MENTIONS IN TRADITIONAL MEDIA

Newspaper	Television	Radio	Online
2,922	5,653	51,105	72,050

TOTAL POTENTIAL AUDIENCE REACH: 657, 677, 772 people.

The AMA's reach was vastly increased from 412,733,350 people the previous year.

SOCIAL MEDIA

TWITTER

Followers – 31,956
Retweets – 16,899
Impressions - 6,258,139

FACEBOOK

Followers - 27,093
Comments – 2,102
Impressions - 752,341

Top Tweet

AMA Media
@ama_media

The AMA is concerned the NSW Govt plan to start reopening lacks important details incl. modelling future cases & impacts on the health system, and ignores warnings that easing when contact tracing is already overwhelmed leads to more cases and greater burden on the health system.

4:10 PM · Sep 9, 2021 · Twitter Web App

961 Retweets **79** Quote Tweets **2,490** Likes

Total Engagements:	10,261
Likes	2,535
Comments	54
Shares	972

Top Post

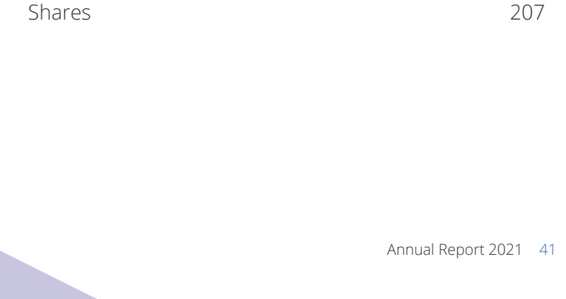
Australian Medical Association
25 July 2021 ·

"It's like the captain of the plane has announced that the plane is going to crash into the sea, and people are worried about which brand of life vest they are going to put on"- Dr Chris Moy on "vaccine snobbery" on ABC TV this morning, urging people in Sydney to get the vaccine available to them.

Dr Moy's further message on this:

Protect yourself: Even one shot of AZ reduces the risk of hospitalisation by 71%, with the second one reduce the risk by 92%. (Source: https://www.health.gov.au/.../atagi-statement-response-to...)

Protect others: Even one shot of either AZ or Pfizer reduces transmission by up to 50%. That is what it's going to take to slow Delta down in Sydney. (Source: https://www.nejm.org/doi/full/10.1056/NEJMc2107717)



Total Engagements:	**3,443**
Reactions	1,213
Comments	177
Shares	207

MEDIA MOMENTS:

The AMA President made a number of important media appearances in 2021, promoting the AMA's work and providing expertise and commentary to media reportage.

Address to the National Press Club

Dr Khorshid appeared at the National Press Club in Canberra on 10 June giving a wide-ranging address which launched the *AMA's Vision for Australia's Health*.

The Vision, a clear blueprint strategy for all governments and players in the sector, is built around five pillars of detailed policy reform: General Practice, Public Hospitals, Private Health, A Health System for All and A Health system for the future.

The speech stated areas the AMA would campaign on in the future and launched a second research paper, *A tax on sugar-sweetened beverages* which describes the health risks of consuming too many sugary drinks and the benefits a tax on them can bring. Dr Khorshid's address was broadcast live on ABC Television and was covered in the Sydney Morning Herald.

Appearance on ABC TV's Q&A program

The AMA President was a guest on the ABC's flagship Q&A program on 10 June, a live special hosted by Stan Grant on the COVID-19 response. Dr Khorshid engaged in a lively debate with the panel.

news.com.au

Omar Khorshid, President of the Australian Medical Association, had heard enough and interjected.

"Are you seriously suggesting that Covid doesn't affect young people or that our border closures haven't made us almost the most successful country in the world when it's come to managing this pandemic?," he asked.

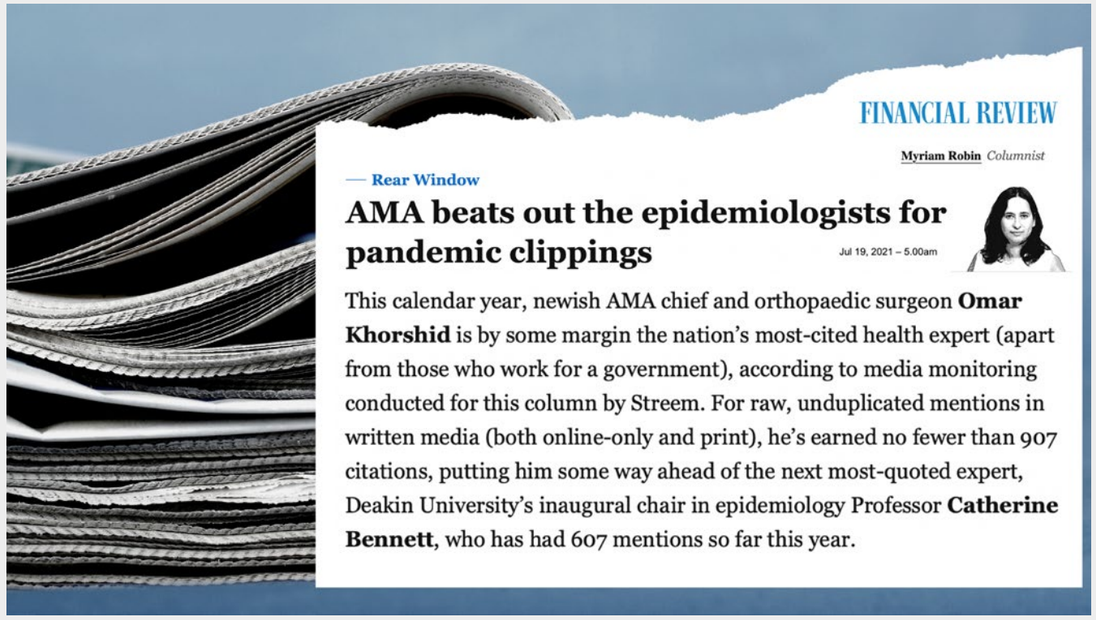
Mr Murray questioned whether Australia had been "the most successful". Dr Khorshid told him Australia had been "extraordinarily successful".

(Source: News.Com. 10 June)

YouTube Collaboration

The AMA partnered with YouTube in 2021 to combat misinformation about COVID vaccines, with Dr Khorshid appearing as a guest expert alongside prominent health communicators Dr Matt Barton and Dr Mike Todorovic.

The series kicked off on Dr Matt and Dr Mike's YouTube Channel with a look at the topic of *COVID-19 Vaccines: Fertility and Pregnancy*, on 23 September garnering 62,575 views.


FINANCIAL REVIEW

Myriam Robin *Columnist*

— Rear Window

AMA beats out the epidemiologists for pandemic clippings

Jul 19, 2021 – 5.00am

This calendar year, newish AMA chief and orthopaedic surgeon **Omar Khorshid** is by some margin the nation's most-cited health expert (apart from those who work for a government), according to media monitoring conducted for this column by Streem. For raw, unduplicated mentions in written media (both online-only and print), he's earned no fewer than 907 citations, putting him some way ahead of the next most-quoted expert, Deakin University's inaugural chair in epidemiology Professor **Catherine Bennett**, who has had 607 mentions so far this year.

AMA unique research papers

In 2021 the AMA released the first three in a series of special research papers. *Putting Health Care back into Aged Care* was launched on 12 April ahead of the Royal Commission final report. *A tax on sugar-sweetened beverages* was launched as part of the AMA's *Vision for Australia's Health* in June. The AMA's analysis of the effects of long-term under funding of Australia's public hospitals, *Cycles of Crisis* was released on 15 October. The reports garnered extensive media coverage.

AMA SUBSIDIARIES:

AMPCo

The Australasian Medical Publishing Company (AMPCo) has three business streams: Data, Advertising and Publishing. Best known for publishing the Medical Journal of Australia (MJA), AMPCo has progressed its business transformation over the last year by successfully transitioning the readership of the MJA from print to digital, expanding use of podcasts and webinars to bring MJA readers content in new formats, and initiating a new data product Illuminate Doctor. The MJA's offshoot publication Insight has expanded its readership reach and provided a growing advertising revenue stream. All this was achieved while also improving the MJA's impact factor to 7.738, ranking the MJA as the 17th best general medical journal internationally.

Doctors Health Services Pty Ltd

Better physical and mental health of every doctor is a key objective of the AMA. Doctors Health Services Pty Ltd is one of the ways in which the AMA contributes to improving the health and wellbeing of doctors. In the course of the last year, Doctors Health Services Pty Ltd has revised its contracting arrangements with the network of doctor health service providers, supported the ACT to commence its own local doctor health service and Tasmania to commence its own local service in late 2022, and worked with the Australian Council on Healthcare Standards to develop and adopt service standards to guide delivery of doctor health services. Work to implement the Every Doctor, Every Setting mental health framework has been commenced, and a new Board of Directors has adopted a new strategic plan to ensure doctor health service expansion in years to come. The work of Doctors Health Services Pty Ltd benefits every doctor and medical student, and is possible only with the funding support of the Medical Board of Australia and Commonwealth Department of Health.

Doctor Portal Learning

Doctor Portal Learning Pty Ltd was transferred to the ownership of AMA WA on 31 December 2021. This transition has enabled DPL to continue provision of professional development learning to every AMA member as an entitlement of membership. It has additionally allowed exploration of the potential for the AMA to be credentialled as a CPD Home.

AMA Fees List

AMA Fees List is an online service for all AMA members to determine fees charged in private medical practice. The Fees List is also used by some government agencies and insurers to inform payment for medical services. As the Fees List approaches fifty years of service, the AMA invested in further upgrades to the Fees List service by reviewing and adjusting certain MBS item numbers, updating the Fees List to incorporate changes advised by the MBS Review and Department of Health, and adjusting commercial and government use licencing agreements. Improvements in system usability have been gradually deployed over the course of the year.

FINANCIAL REPORT

General Purpose Financial Report

Australian Medical Association Limited and Controlled Entities
ABN 37 008 426 793
For the financial year 31 December 2021

CONTENTS

DIRECTORS REPORT

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

A/Professor Rosanna Capolingua
MBBS, FAMA, MRACGP, FAICD
Chair
Investment Committee member
General Practitioner

Dr Jessica Dean
BMedSci (Hons), MBBS (Hons), LLB, GAICD
ICU Registrar
(Board Member from 28 May 2021)

Dr Antonio Di Dio
MBBS (USYD) DipRACOG FRACGP
Audit, Risk and Performance Committee member
General Practitioner

Dr Stephen Gourley
MBBS, Grad Dip CE, MHM, MPH, FRCEM, FACEM, MAICD, AFRACMA
Deputy Chair
Audit, Risk and Performance Committee member
Investment Committee member
Head of Emergency Medicine

Dr Ruth Kearon
FRACGP
Director of Health Workforce, Planning Unit, Department of Health
(Board Member from 28 May 2021)

Dr Katherine Kearney
FRACP, BPharm, MBBS, MMed (Clin Epi)
Chair, Audit, Risk and Performance Committee
Cardiologist

Dr Omar Khorshid
MBBS, FRACS, FAOrthA, FAMA, AdvDipMgt, GAICD
President
Orthopaedic Surgeon

Dr Bavahuna Manoharan
MBBS, MPH, BSc, CHIA, GAICD
State Clinical Director

Dr Helen McArdle
BMedSc, MBBS, MPH, FAFOEM, FRACMA, FAICD
Audit, Risk and Performance Committee Chair
Specialist Medical Administrator and Occupational Physician (Board Member until 28 May 2021)

Dr Chris Moy
MBBS, FRACGP, FAMA
Vice President
General Practitioner

A/Professor Gino Pecoraro
MBBS, MRACOG, FRANZCOP
Chair
Obstetrician & Gynecologist
(Board Member until 28 May 2021)

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

A/Professor William Tam
MBBS, FRACP, PhD
Senior Gastroenterologist

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 2021, the consolidated Group recorded a total comprehensive income of $2.5 million (2020: $2.3 million).

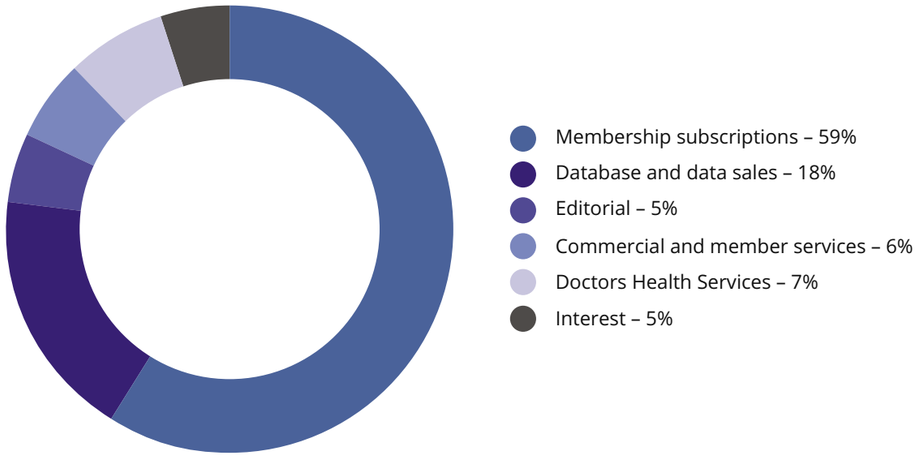
The consolidated comprehensive income for the year, is net of accounting for changes in fair value of long- term investments that are reflective of valuation at reporting date. A higher performance in unrealised capital was recorded this year and offsets the downturn recorded at the end of last year, reflecting the Board's assessment that the Group's long term investment portfolio is in a strong position to ride downward trends.

The Group's operations are largely unchanged apart from continued variation to the format of meetings and the requirement for remote worksites, in line with Government requirements. During the year, the Federal Secretariat moved it's Canberra office to newly leased premises on 39 Brisbane Avenue. Recognition of the commencement of this lease for the right to utilise the asset and the liability for inccurrence of rent is reflected in the accounts this year. Subsequent to reporting date, on 1 January 2022, operations of Doctorportal Pty Ltd was transferred to AMA Western Australia with services to all subscribers, members and non-members alike, to continue as is. At the time of reporting, there are no other strong indicators to suggest material financial impacts to the Group's results in future financial years from on-going operations.

Revenue

Compared to 2020, total revenue from operations, remained consistent at $21.9 million (2020: $21.9 million).

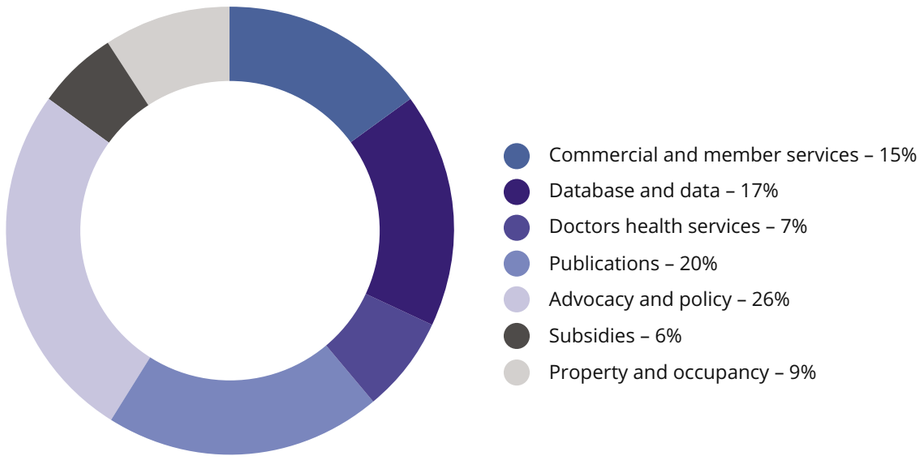
Graph 1 – Distribution of revenue



Expenses

Total expenses (before income tax) increased by 7.6% (2020: decrease 5.7%) to $21.3 million (2020: $19.8 million). Increases in spending in 2021, includes investment on initiatives that inform long-term business improvements.

Graph 2 – Distribution of expenses (excluding income tax)



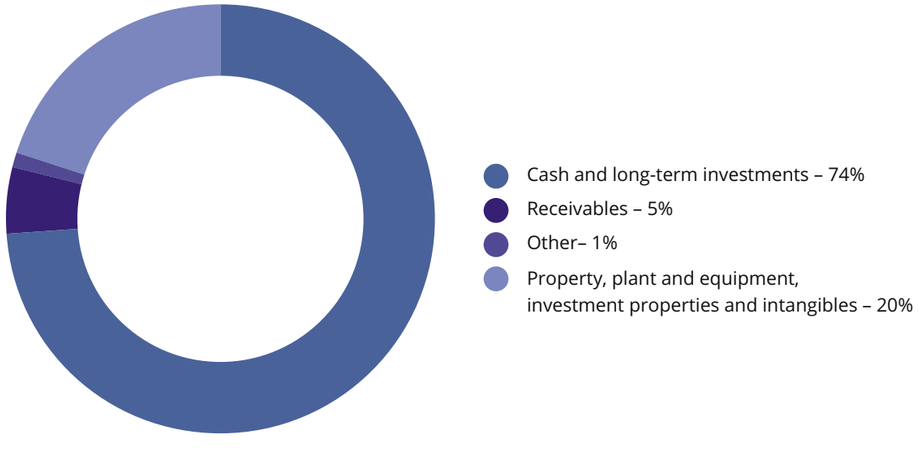
Review of financial position

Net assets increased 8.3% to $32.5 million compared to prior year (2020: increased 8.7% to $30.0 million).

Assets

Total assets increased 22.3% to $43.9 million compared to prior year (2020: $35.9 million). Two main contributors to this increase is the recognition of the right to use the new office in Canberra, which is a leased premise, and a favourable increase in unrealised capital in the long term investment portfolio.

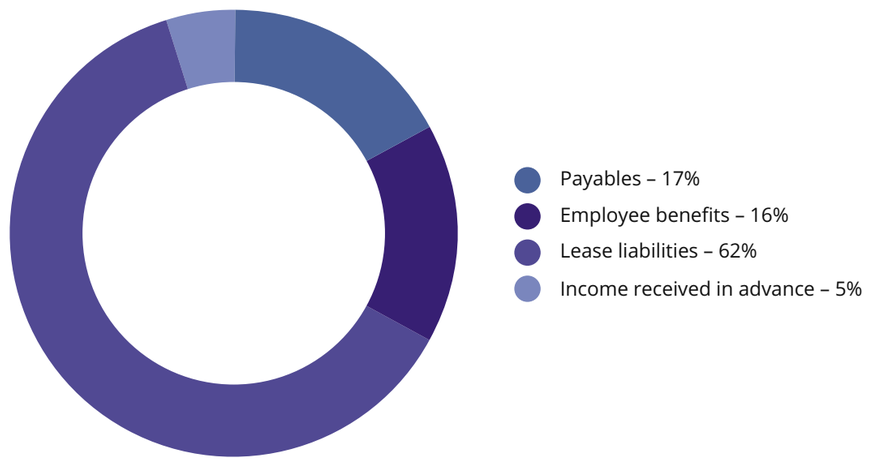
Graph 3 – Distribution of assets



Liabilities

Total liabilities increased 90.0% to $11.4 million compared to prior year (2020: $6.0 million). The main contributor is the recognition of a lease liability for the new office in Canberra.

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 are in progress 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 91.

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 2021, 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 2021 to 31 December 2021 the Board met on 10 occasions.

The Audit, Risk and Performance Committee met 3 times. Three members of the Committee are Directors and one is an independent appointment.

The Investment Committee met 7 times. All three members of the Committee are Directors.

The following tables summarises the meeting attendance of the Directors and Committee members during 2021, noting the number of meetings each Director/Committee member was eligible to attend and attended.

	BOARD MEETINGS	
	ELIGIBLE TO ATTEND	ATTENDED
Dr Omar Khorshid	10	10
Dr Chris Moy	10	9
A/Prof Rosanna Capolingua	10	10
Dr Stephen Gourley	10	10
Dr Gary Speck	10	10
A/Prof William Tam	10	10
Dr Katherine Kearney	10	10
Dr Antonio Di Dio	10	8
Dr Bavahuna Manoharan	9	7
Dr Jessica Dean	7	7
Dr Ruth Kearon	6	6
A/Prof Gino Pecoraro	4	4
Dr Helen McArdle	4	4

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

INVESTMENT COMMITTEE		
	ELIGIBLE TO ATTEND	ATTENDED
Dr Gary Speck	7	7
A/Prof Rosanna Capolingua	7	7
Dr Stephen Gourley	5	5

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

Dr Rosanna Capolingua
Chair
Australian Medical Association Limited

STATEMENT OF COMPREHENSIVE INCOME

FOR THE YEAR ENDED 31 DECEMBER 2021

		Consolidated	
		2021	2020
	Note	$'000	$'000
Revenue		20,892	20,287
Other income		1,018	1,641
	2	21,910	21,928
Expenses			
Employment		(13,339)	(12,378)
Publications		(520)	(977)
Database and data		(52)	(41)
Advocacy and policy		(497)	(507)
Subsidies	2	(1,345)	(1,227)
Commercial and member services		(172)	(107)
Doctors Health Services		(1,423)	(1,673)
Property and occupancy		(1,350)	(877)
Depreciation and amortisation		(646)	(413)
Administration	2	(1,971)	(1,551)
		(21,315)	(19,751)
Profit before income tax		595	2,177
Income tax credit/(expense)	4	457	256
Profit for the year		1,052	2,433
Other comprehensive income			
Changes in fair value of investments at fair value through other comprehensive income		1,945	(144)
Income tax relating to these items		(482)	46
Other comprehensive income for the year, net of tax		1,463	(98)
Total comprehensive income for the year		2,515	2,335

STATEMENT OF FINANCIAL POSITION

AS AT 31 DECEMBER 2021

	Note	Consolidated 2021 $'000	Consolidated 2020 $'000
Assets			
Current assets			
Cash and cash equivalents	5	8,403	8,405
Trade and other receivables	6	2,092	1,742
Inventories	7	32	14
Prepayments	8	213	253
Financial investments	9	1,625	437
Total current assets		12,365	10,851
Non-current assets			
Financial investments	9	22,537	20,455
Intangible assets	10	1,357	1,790
Property, plant and equipment	11	1,864	518
Deferred tax assets	12	278	303
Right-of-use assets	13	5,529	2,026
Total non-current assets		31,565	25,092
Total assets		43,930	35,943
Liabilities			
Current Liabilities			
Trade and other payables	14	2,488	2,365
Lease liabilities	13	900	847
Employee benefits	15	1,588	1,352
Income tax payable	16	-	-
Total current liabilities		4,976	4,564
Non-current liabilities			
Employee benefits	15	223	112
Make good provision	13	159	-
Lease liabilities	13	6,073	1,283
Total non-current liabilities		6,455	1,395
Total liabilities		11,431	5,959
Net assets		32,499	29,984
Equity			
Retained earnings		30,745	29,693
Reserve		1,754	291
Total equity		32,499	29,984

STATEMENT OF CHANGES IN EQUITY

FOR THE YEAR ENDED 31 DECEMBER 2021

Consolidated	Retained earnings $'000	Reserve $'000	Total Equity $'000
At 1 January 2020	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
Profit for the year	1,052	-	1,052
Other comprehensive income	-	1,463	1,463
Total comprehensive income for the year	1,052	1,463	2,515
At 31 December 2021	30,745	1,754	32,499

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 31 DECEMBER 2021

	Note	Consolidated 2021 $'000	2020 $'000
Cash flow from operating activities			
Receipts from membership subscriptions		13,293	13,356
Other receipts from customers		9,689	9,921
Payment to suppliers and employees		(21,366)	(20,712)
Interest received		17	41
Net cash flow from operating activities		1,633	2,606
Cash flow from investing activities			
Payments for intangible assets	10	(78)	(1,132)
Payments for property, plant and equipment	11	(306)	(64)
Proceeds from investments		981	870
Payments for other investments		(1,325)	(1,151)
Net cash flow used in investing activities		(728)	(1,477)
Cash flow from financing activities			
Repayment of lease liabilities	13	(907)	(949)
Net cash flow used in financing activities		(907)	(949)
Net (decrease)/increase in cash held		(2)	180
Cash and cash equivalents at the beginning of the year		8,405	8,225
Cash and cash equivalents at the end of the year		8,403	8,405

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

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 2022.

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.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

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.

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.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

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.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

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.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

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:

	2021	2020
Buildings	**2.5% - 4%**	2.5% - 4%
Office Furniture	**5% - 25%**	5% - 25%
Office Equipment	**10% - 50%**	10% - 50%
Fixture and Fittings	**5% - 10%**	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:

	2021	2020
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.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

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.

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	
	2021	**2020**
	$'000	**$'000**
Revenue		
Membership subscriptions	**12,284**	12,232
Database and data sales	**3,887**	3,565
Editorial	**1,004**	907
Commercial and member services	**1,233**	1,262
Doctors Health Services including Telehealth grant	**1,486**	1,410
Interest	**17**	41
Interest from investments at fair value through other comprehensive income	**981**	870
Other income		
Government assistance - Jobkeeper	**-**	587
Government assistance - Cash flow boost	**-**	257
Other revenue including recoveries	**1,018**	797
	21,910	21,928
Expenses		
Contributions to employee superannuation plans	**992**	930
Cost of goods sold	**17**	48
Repairs and maintenance	**64**	100
Subsidies		
Subsidies to AMA States and Territories	**1,282**	1,188
Other subsidies	**63**	39
	1,345	1,227
Administration		
Loss on disposal of assets	**67**	3
Insurance	**74**	83
Travel and accommodation	**60**	135
Other	**1,770**	1,330
	1,971	1,551

Note 3 Auditor's Remuneration

	Consolidated	
	2021	2020
	$'000	$'000
Audit services		
Auditors of the Group		
Audit of financial report	**56**	64
Other services		
Auditors of the Group		
Taxation services	**17**	20
	73	84

Note 4 Income tax credit/(expense)

	Consolidated	
	2021	2020
	$'000	$'000
Current tax credit/(expense)		
Current tax on profits for the year	**-**	-
	-	-
Deferred tax credit/(expense)		
Origination and reversal of temporary differences	**70**	436
Prior year adjustments	**387**	(180)
	457	256
Total income tax credit/(expense) in income statement	**457**	256
Profit before income tax	**(595)**	(2,177)
Income tax using the domestic corporation tax rate 26% (2020: 26%)	**(155)**	(566)
Increase in income tax expense due to:		
Mutual expenditure	**(3,015)**	(2,910)
Non-deductible expenses	**(1)**	(1)
Sundry	**(62)**	(18)
	(3,078)	(2,929)
Decrease in income tax expense due to:		
Mutual income	**3,261**	3,743
Fully franked dividends	**42**	-
Sundry	**-**	188
	3,303	3,931
Net change in income tax	**70**	436
Over/(under) provision for prior year - deferred tax expense	**387**	(180)
	387	(180)
Income tax credit/(expense)	**457**	256
Attributable to:		
Continuing operations	**457**	256

Note 5 Cash and Cash Equivalents

	Note	Consolidated 2021 $'000	Consolidated 2020 $'000
Cash at bank	17(b)	**5,103**	5,055
Short-term deposits (less than 3 months' maturity)	17(b)	**3,300**	3,349
Cash on hand		**-**	1
Total Cash and cash equivalents	17	**8,403**	8,405

(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 $1.1 million (2020: $1.3 million), which are held by Doctors Health Services Pty Ltd. These monies are subject to grant funding arrangement restrictions and are therefore not available for general use by the other entities within the Group.

Note 6 Trade and other receivables

Trade receivables		**648**	541
Other receivables		**1,444**	1,201
Total Trade and other receivables	17	**2,092**	1,742

(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 2021 $'000	Consolidated 2020 $'000
Finished goods		**32**	14
Total Inventories		**32**	14

Note 8 Prepayments

Prepayments		**213**	253
Total prepayments		**213**	253

Note 9 Financial investments

Current assets			
Financial assets at amortised cost			
Short-term deposits (more than 3 months' maturity)	17	**1,625**	437
Total Current		**1,625**	437
Non-current assets			
Financial assets at fair value through other comprehensive income			
Managed securities fund	17	**22,537**	20,455
Total Non-current		**22,537**	20,455
Total Financial investments		**24,162**	20,892

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	
	2021	**2020**
	$'000	**$'000**
Development - at cost	**752**	752
Less: Accumulated amortisation	**(451)**	(194)
	301	558
Computer software - at cost	**1,694**	717
Less: Accumulated amortisation	**(638)**	(429)
	1,056	288
Development in progress - at cost	**-**	944
	-	944
Total Intangible assets	**1,357**	1,790

Movement in carrying amounts:

	Development	**Computer software**	**Development in progress**	**Total**
	$'000	**$'000**	**$'000**	**$'000**
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
31 December 2021				
Opening written down value	**558**	**288**	**944**	**1,790**
Additions	**-**	**-**	**78**	**78**
Transfer	**-**	**1,022**	**(1,022)**	**-**
Amortisation	**(257)**	**(254)**	**-**	**(511)**
Closing written down value	**301**	**1,056**	**-**	**1,357**

Note 11 Property, plant and equipment

	Consolidated	
	2021	2020
	$'000	$'000
Property, Parap Rd, Parap - at cost	381	381
Less: Accumulated depreciation	(98)	(89)
	283	292
Office furniture - at cost	474	570
Less: Accumulated depreciation	(326)	(524)
	148	46
Office equipment - at cost	1,003	866
Less: Accumulated depreciation	(769)	(763)
	234	103
Fixtures and fittings - at cost	1,185	91
Less: Accumulated depreciation	(55)	(59)
	1,130	32
Computer hardware - at cost	424	439
Less: Accumulated depreciation	(355)	(394)
	69	45
Total Property, plant and equipment	1,864	518

An independent valuation of 2/25 Parap Road, Northern Territory was performed in December 2021 and valued at $400,000. Territory Property Consultants 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 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
31 December 2020						
Property, Parap Rd Parap	292	-	-	(9)	-	283
Office furniture	46	157	(25)	(30)	-	148
Office equipment	103	197	(23)	(43)	-	234
Fixture and fittings	32	1,121	(6)	(17)	-	1,130
Computer hardware	45	71	(11)	(36)	-	69
	518	1,546	(65)	(135)	-	1,864

Note 12 Deferred tax assets and liabilities

Consolidated	Deferred Tax Assets 2021	Deferred Tax Assets 2020	Deferred Tax Liabilities 2021	Deferred Tax Liabilities 2020	Total 2021	Total 2020
	$'000	$'000	$'000	$'000	$'000	$'000
Leases	52	-	-	(297)	52	(297)
Property, plant and equipment	-	-	(11)	(13)	(11)	(13)
Income in advance	-	-	(103)	(269)	(103)	(269)
Employee benefits	246	148	-	-	246	148
Investments	-	-	(584)	(102)	(584)	(102)
Others	1	47	-	-	1	47
Carried forward losses	677	789	-	-	677	789
Total Deferred tax assets/ (liabilities)	976	984	(698)	(681)	278	303

Movement in temporary differences:	Leases	Property, plant and equipment	Income in advance	Employee benefits	Investments	Others	Carried forward losses	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Consolidated								
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
31 December 2021								
Opening written down value	(297)	(13)	(269)	148	(102)	47	789	303
Recognised in income statement	349	2	166	98	-	(46)	(112)	457
Recognised in equity	-	-	-	-	(482)	-	-	(482)
Closing written down value	52	(11)	(103)	246	(584)	1	677	278

Note 13 Leases

	Building $'000	Consolidated Equipment $'000	Total $'000
(i) Amounts recognised in the balance sheet			
Assets			
Right-of-use assets			
31 December 2020			
Opening written down value	**1,567**	-	1,567
Additions	**1,257**	-	1,257
Depreciation	**(798)**	-	(798)
Closing written down value	**2,026**	-	2,026
31 December 2021			
Opening written down value	**2,026**	**-**	**2,026**
Additions	**4,402**	**125**	**4,527**
Depreciation	**(1,021)**	**(3)**	**(1,024)**
Closing written down value	**5,407**	**122**	**5,529**

	Consolidated 2021 $'000	Consolidated 2020 $'000
Liabilities		
Lease liabilities		
Current	**900**	847
Non-current	**6,073**	1,283
	6,973	2,130
Make good provision		
Non-current	**159**	-

As at 31 December 2021, the Group has three office leases and one IT equipment lease. During the year, the Group entered into a new 12 year office lease ending 30 June 2033 at Level 1, 39 Brisbane Avenue, Barton ACT. In accordance with note 1(p) and AASB 16 Leases, the Group has recognised a right-of-use asset and lease liability at the commencement of the lease.

(ii) Amounts recognised in the statement of profit or loss		
Interest expense	**142**	61

Note 13 Leases (continued)

(iii) Amounts recognised in the statement of cash flows		
Lease payments	**907**	949
(iv) Non-cash investing and financing activities		-
Acquisition of office fit-outs and furniture from lessor as lease incentive	**1,240**	-

Note 14 Trade and other payables

	Consolidated	
	2021	**2020**
	$'000	**$'000**
Trade payables	**301**	360
Other payables and accruals	**1,596**	1,236
Income in advance	**591**	769
Total Trade and other payables	**2,488**	2,365

Trade payables are unsecured and are usually paid within 30 days of recognition.

Note 15 Employee benefits

Current		
Long service leave provision	**569**	526
Annual leave provision	**1,019**	826
	1,588	1,352
Non-current		
Long service leave provision	**223**	112
Total Employee benefits	**1,811**	1,464

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	
		2021	**2020**
	Note	**$'000**	**$'000**
Financial assets			
Cash and cash equivalents	5	**8,403**	8,405
Trade and other receivables	6	**2,092**	1,742
Financial assets at amortised costs	9	**1,625**	437
Financial assets at fair value through other comprehensive income	9	**22,537**	20,455
		34,657	31,039

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	
		2021	2020
	Note	$'000	$'000
Variable rate instruments			
Financial assets			
Cash at bank	5	**5,103**	5,055
		5,103	5,055
Fixed rate instruments			
Financial assets at amortised costs			
Short term deposits			
- less than 3 months' maturity	5	**3,300**	3,349
- more than 3 months' maturity	9	**1,625**	437
		4,925	3,786

(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

		Consolidated	
		2021	2020
	Note	$'000	$'000
Financial assets			
Non-current assets			
Financial assets at fair value through other comprehensive income			
Managed fund - Australian securities		**15,833**	13,472
Managed fund - International securities		**6,704**	6,983
	9	**22,537**	20,455

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	
	2021	**2020**
	$'000	**$'000**
Expenditure commitment:		
Not later than 1 year	**37**	207
Later than 1 year but not later than 5 years	**95**	-
	132	207
Commitments receivable		
Not later than 1 year	**61**	35
Later than 1 year but not later than 5 years	**192**	-
	253	35

The Australian Medical Association Limited (AMA) renewed its on-going Memorandum of Understanding with the Australian Medical Students' Association Limited (AMSA), which continues to provide financial support in the form of cash sponsorship, direct employment and in-kind back office support.

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	
	2021	**2020**
	$'000	**$'000**
Total remuneration	**2,814**	3,373

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	
	2021	**2020**
	$'000	**$'000**
The Indigenous Peoples' Medical Scholarship Trust Fund	**51,178**	61,005
The AMA Indigenous Medical Scholarship Foundation	**217,301**	190,717
	268,479	251,722

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

A Deed of Transfer was signed between AMA Limited and AMA Services (WA) Pty Ltd to transfer all assets and liabilities relating to Doctorportal Learning Pty Ltd from 1 January 2022 for a cash consideration of $1. As at 31 December 2021, the net assets of Doctorportal Learning Pty Ltd was $1.

No other matter or circumstance has arisen since the end of the financial year to the date of this report, which has significantly affected or may significantly affect the operations of the economic entity, the results of those operations or the state of affairs of the economic entity in subsequent financial years.

Note 22 Parent entity

As at, and throughout the financial year ended 31 December 2021, 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.

	2021	2020
	$'000	$'000
(a) Financial information		
Earnings before interest and tax	**(1,240)**	(487)
Interest income	**862**	799
(Loss)/profit before tax	**(378)**	312
Trust distribution - AMA Property Trust	**-**	7,011
Income tax credit/(expense) *	**458**	256
Profit for the year	**80**	7,579
Changes in fair value of investments at fair value through other comprehensive income (net of income tax)	**1,294**	(62)
Total comprehensive profit	**1,374**	7,517

* 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)

	2021	2020
	$'000	$'000
Statement of financial position		
Assets		
Current assets	**6,292**	5,504
Non-current assets	**27,311**	20,475
Total assets	**33,603**	25,979
Liabilities		
Current liabilities	**2,505**	2,090
Non-current liabilities	**7,426**	1,591
Total liabilities	**9,931**	3,681
Equity		
Retained earnings	**22,154**	22,073
Reserve	**1,518**	225
Total equity	**23,672**	22,298

(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	
	2021	2020
	$'000	$'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
	6	6

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

		Equity holding	
Name of entity	Class of shares	2021 %	2020 %
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

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 Level 1, 39 Brisbane Avenue, 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 Level 1, 39 Brisbane Avenue, Barton ACT 2600. This company 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 Level 1, 39 Brisbane Avenue, 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 Level 1, 39 Brisbane Avenue, Barton, ACT 2600. This company manages the delivery of health services for medical practitioners 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 Level 1, 39 Brisbane Avenue, Barton, ACT 2600. This company manages the delivery of online accredited medical education for both members and non-members.

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 2021 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

Dr Rosanna Capolingua

Chair
Australian Medical Association Limited

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AUDITOR'S INDEPENDENCE DECLARATION UNDER S307C OF THE CORPORATIONS ACT 2001 TO THE DIRECTORS OF AUSTRALIAN MEDICAL ASSOCIATION LIMITED

As lead auditor of Australian Medical Association Limited and its Controlled Entities, I declare that, to the best of my knowledge and belief, during the year ended 31 December 2021 there have been no contraventions of:

i. the auditor independence requirements as set out in the *Corporations Act 2001* in relation to the audit; and
ii. any applicable code of professional conduct in relation to the audit.

Shane Bellchambers, FCA
Registered Company Auditor
BellchambersBarrett

Canberra, ACT
Dated this 21st day of April 2022

Liability limited by a scheme approved under Professional Standards Legislation

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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF AUSTRALIAN MEDICAL ASSOCIATION LIMITED

Report on the Audit of the Financial Report

Opinion

We have audited the accompanying financial report of Australian Medical Association and its subsidiaries (the Group), which comprises the statement of financial position as at 31 December 2021, the statement of profit or loss and other comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and the directors' declaration.

In our opinion, the 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 2021 and of its 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 believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Information Other than the Financial Report and Auditor's Report Thereon

The directors are responsible for the other information. The other information comprises the information included in the annual report for the year ended 31 December 2021 but does not include the financial report and our auditor's report thereon. 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.

Other Matter

The financial report of the company for the year ended 31 December 2020 was audited by another auditor who expressed an unmodified opinion on that financial report on 22 April 2021.

Responsibilities of the Directors for the Financial Report

The directors of the Group 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 is free from material misstatement, whether due to fraud or error.

Liability limited by a scheme approved under Professional Standards Legislation

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF AUSTRALIAN MEDICAL ASSOCIATION

In preparing the financial report, the directors are responsible for assessing the Group's ability 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 Responsibility 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.

As part of an audit in accordance with the Australian Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Group's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the directors.
- Conclude on the appropriateness of the directors' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Group's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Group to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the directors regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Shane Bellchambers, FCA
Registered Company Auditor
BellchambersBarrett

Canberra, ACT
Dated this 21st day of April 2022

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