Australian Medical Association

Annual Report 2017

AMA

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AMA

Australian Medical Association Limited

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2017 AMA Federal Councillors

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Prof Robyn Langham
Prof Steve Kisely

Prof Mark Khangure
A/Prof Susan Neuhaus
Dr John Zorbas
Dr Sandra Hirowatari
A/Prof Julian Rait
Dr Roderick McRae
Mr Rob Thomas

1.

President's Report

It was a very busy and very successful year for the Federal AMA in 2017. Your elected representatives and the hardworking staff in the Secretariat in Canberra delivered significant achievements in policy, advocacy, political influence, professional standards, doctors' health, media profile, and public relations.

We worked tirelessly to ensure that health policy and bureaucratic processes were shaped to provide the best possible professional working environments for Australian doctors and the highest quality care for our patients.

Our priority at all times was to provide value for your membership of the AMA.

This is a summary of the work we undertook on behalf of our valued members, the broader medical profession, and the Australian community.

General Practice and Workplace Policy

- Our strong advocacy led to a decision to **lift the freeze** on Medicare patient rebates.
- The AMA coordinated **Doctors' Health Services** around the country, with funding support from the Medical Board of Australia.
- We launched the **AMA Safe Hours Audit Report**, giving added focus to the issue of doctors' health and wellbeing.
- We maintained a strong focus on medical workforce and training places, with the National Medical Training Network significantly increasing its workforce modelling and projection work following sustained advocacy by the AMA.

Dr Michael Gannon
President

- We secured a number of concessions in the proposed **redesign of the Practice Incentive Program** (PIP), as well as a delay in the introduction of changes.
- We lobbied at the highest level for a more durable solution to concerns over **Pathology** collection centre rents, focusing on effective compliance, and achieving a fair balance between the interests of GP members and pathologist members.
- The AMA led the **reforms to After-hours GP services** provided through Medical Deputising Services (MDSs) to ensure that these services are better targeted and there is stronger communication between the MDS and a patient's usual GP.
- We **successfully lobbied the ACCC** to renew the AMA's existing authorisation that permits GPs to engage in intra-practice price setting, potentially saving GPs thousands of dollars annually in legal and other compliance costs.
- We ensured a proportionate response from the Government in response to concerns over the **security of Medicare** card numbers, avoiding more draconian proposals that would have added to the compliance burden on practices, and added a barrier to care for patients.

Our priority at all times was to provide value for your membership of the AMA.

Medical Practice

- We fundamentally altered the direction of the **Medical Indemnity Insurance Review**, discussing its importance to medical practice at the highest level, helping to ensure the review is not used as a blunt savings exercise, and saving doctors and their patients millions of dollars in increased premiums.
- We led a nationally co-ordinated campaign with the State AMAs and other peak bodies to uphold the TGA's decision to up-schedule **codeine**.
- We campaigned against an inadequate, poorly conceived, and ideological **National Maternity Services Framework**, which has now been scrapped.

- We campaigned on the issue of **Doctors' Health** and the need for COAG to change mandatory reporting laws, promoting the Western Australian model.
- We launched the **AMA Public Hospital Report Card**.
- We pressed the case for vastly improved **Private Health Insurance** products through membership of the Private Health Ministerial Advisory Committee (PHMAC), my annual National Press Club Address, an appearance before a Senate Select Committee, and regular and ongoing media and advocacy.
- We launched the **AMA Private Health Insurance Report Card**.
- We successfully convinced the Government to address concerns with the MBS Skin items, and will continue to do so with the **MBS Review** more broadly.
- We successfully lobbied for changes to the direction of the **Anaesthesia Clinical Committee** of the MBS Review.
- We launched a new **AMA Fees List** with all the associated benefits of mobility and regular updates.
- We saw a number of our **Aged Care policy** recommendations included in a number of Government reviews.
- We lobbied against the ill-thought-out Revalidation proposal, which resulted in a vastly improved **Professional Performance Framework** based around enhanced continuing professional development.
- The AMA successfully held off the latest attempt to have a non-Medical Chair of the Medical Board of Australia appointed.

Public Health

- We launched the **AMA Indigenous Health Report** Card, which focused on ear health, and specifically chronic otitis media, in conjunction with the Minister for Indigenous Health, The Hon Ken Wyatt AM.
- We led the medical community by being the first to release a Position Statement on **Marriage Equality**, and advocated for the legislative change that eventuated in late 2017.
- We released the updated AMA Position Statement on **Obesity**, following a policy session at the AMA National Conference, which brought together representatives from the medical profession, sports sector, food industry, and health economists.
- We launched the AMA Position Statement on an Australian **Centre for Disease Control** (CDC), which was welcomed by experts in communicable diseases.
- We released the AMA Position Statement on **Female Genital Mutilation**, which provided a platform for the AMA to engage in advocacy on preventing this practice.
- We released the AMA Position Statement on Infant **Feeding and Maternal Health**.
- We released the progressive and widely-supported AMA Position Statement on **Harmful substance use, dependence, and behavioural addiction (Addiction)**.
- We successfully lobbied against the proposal to **drug test welfare recipients**, including a strongly worded submission to a Parliamentary Inquiry on the proposal, which resulted in defeat of the proposed measure in the Parliament.
- We released the AMA Position Statement on **Firearms**, generating considerable media coverage and interest, in Australia and overseas. Most importantly, it is a factor in Australia maintaining its tough approach to gun control.
- We released the AMA Position Statement on **Blood Borne Viruses** (BBVs), which called for needle and syringe programs (NSPs) to be introduced in prisons and other custodial settings to reduce the spread of BBVs. This policy has been promoted by other health organisations and saw the AMA create strong ties within the sector.
- We conducted ongoing and prominent advocacy for the health and wellbeing of **Asylum Seekers** and Refugees, including a meeting with the Minister for Immigration and Border Protection, The Hon Peter Dutton MP, and lobbying on behalf of individual patients behind the scenes.

- AMA lobbying of manufacturers saw a change to the sale of **sugar-sweetened beverages** in some remote Aboriginal communities, which will improve health outcomes.
- We promoted the benefits of **Immunisation** to individuals and the broader community. Our advocacy has contributed to an increase in child and adult vaccination rates.
- We provided strong advocacy on **climate change** and health.
- We consistently advocated for better **women's health services**.
- The AMA lobbied for the establishment of a No-Fault Compensation Scheme for people adversely affected by **vaccines**.

A major activity was promotion of our carefully-constructed Position Statement on **Euthanasia and Physician Assisted Suicide** during consideration of legislation in Tasmania, Victoria, NSW, and WA.

The Federal Council endorsed Position Statements on **Mental Health**, **Road Safety**, **Nutrition**, **Organ Donation and Transplantation**, and **Rural Workforce**, ready for release in early 2018.

As your President, I had face-to-face meetings with Prime Minister Malcolm Turnbull, Opposition Leader Bill Shorten, Health Minister Greg Hunt, Shadow Health Minister Catherine King, Greens Leader Dr Richard Di Natale, and a host of Ministers and Shadow Ministers.

The Secretariat also organised lunch briefings with backbenchers from all Parties to promote AMA policies.

In July, our advocacy was publicly recognised when the Governance Institute rated the AMA as **the most ethical and successful lobby group** in Australia.

I met regularly with stakeholders across the health sector, including the Colleges, Associations, and Societies, other health professional groups, and consumer groups.

As your President, I was also active on the international stage, representing Australia's doctors at meetings in Zambia, Britain, Japan, and the United States.

The highlight of the international calendar was the annual General Assembly of the **World Medical Association**. Outcomes from that meeting included high level discussions on end-of-life care, numerous ethical issues, doctors' health, and an editorial revision of the **Declaration of Geneva**.

But our primary focus was at home, and your AMA was very active in promoting our Mission: *Leading Australia's Doctors – Promoting Australia's Health*.

We had great successes. We earned and maintained the respect of our politicians, the bureaucracy, and the health sector. We won the support of the public as we have fought for a better health system for all Australians.

We worked hard to add even greater value to your AMA membership. It has been an honour and a pleasure to serve you as President.

Dr Michael Gannon
President

2.

Secretary General's Report

The AMA has continued to live up to its mission statement of *Leading Australia's Doctors – Promoting Australia's Health*. The past year has seen the AMA contribute to a complex array of health policy issues. The reviews instituted by the Federal Government over the past two years are ongoing with a focus on medical workforce, Medicare Benefit Schedule items, and private health insurance.

The AMA negotiated with the Federal Government on the Federal Budget outcomes, which delivered a gradual lifting of the freeze on Medicare items. While the AMA would have preferred a more rapid lifting of the freeze, any movement was welcome given the accumulated impact of the prolonged freeze on both practices and patients.

Federal Council, under the leadership of Dr Beverley Rowbotham as Chair of Council, continued its focus on policy issues with a full agenda during 2017. Council considered issues as diverse as the transparency of medical fees and the roll out of the National Disability Insurance Scheme.

Federal Council also dealt with issues that were controversial for some members, such as AMA support for the recognition of marriage equality. All AMA Position Statements and policies are brought to Federal Council as the peak policy-making body, often with robust debate before adoption of a final position.

In late 2016, Federal Council established its Equity Inclusion and Diversity Committee to consider ways in which the AMA could better promote and incorporate these principles into its own operations. The Committee is developing

Anne Trimmer
Secretary General

a racism statement and examining ways to support greater diversity within the AMA membership and on its representative bodies.

The seminal AMA report cards – Public Hospital Report Card, Private Health Insurance Report Card, and the Indigenous Health Report Card – all generated public debate on key issues for our community.

The Board, led by Dr Iain Dunlop as Chair, had a successful year, capped off with adoption of a new strategic plan for the period 2018-2020. As this plan will come into effect after the reporting period, I will not address it in detail other than to say that it encompasses the AMA's leadership on advocacy, recognition of our members, strengthening our AMA community, and ensuring our financial security.

As reported at the 2017 Annual General Meeting, the Board took the decision in 2016 to sell the AMA headquarters in Canberra in order to generate better returns on members' funds. In late 2017, the Board received, and accepted, an outstanding offer for the property with settlement of the sale expected in early 2018. I thank the Investment Committee of the Board, with Dr Gary Speck as Chair, which has undertaken the significant task of analysing all aspects of the sale prior to full Board approval.

The two major subsidiaries of the AMA, Doctors' Health Services Pty Limited (DrHS) and Australasian Medical Publishing Company Pty Limited (AMPCo), had successful years. DrHS entered the third year of the funding agreement that the AMA has with the Medical Board of Australia and the Australian Health Practitioner Regulation Agency for the delivery of health services to doctors and medical students across the country. Significant work has been undertaken by DrHS in embedding services in parts of Australia where there had been no services previously. More work is needed to complete this process but it is well underway.

Significant work has been undertaken by DrHS in embedding services in parts of Australia where there had been no services previously.

AMPCo continues to grow its digital platform, doctorportal, with the development of a strong catalogue of learning content. AMPCo's flagship product, the *Medical Journal of Australia,* continues to develop under the leadership of Laureate Professor Nicholas Talley, with a significantly improved impact factor in 2017.

The AMA remains involved in international forums with participation by the President in the Confederation of Medical Associations of Asia and Oceania, and in the World Medical Association. Australia holds one of the elected positions on the WMA Council which provides an opportunity for the AMA to contribute to the development of international policies and activities on behalf of doctors.

This will be my last report to you as Secretary General as I step down from the position in August 2018 when my contract expires. It has been a privilege to work for the AMA and its members over the past five years.

I would like to thank and recognise the support and friendship of the outgoing President, Dr Michael Gannon, the Vice President, Dr Tony Bartone, the Chair of the Board, Dr Iain Dunlop, the Chair of Federal Council, Dr Beverley Rowbotham, and the members of each of the Board and Federal Council. I also acknowledge the collegiality shown me by my State and Territory colleagues.

Finally, I would like to thank the outstanding team that makes up the Secretariat of Federal AMA, and its subsidiary companies. The members of the AMA are well served by a dedicated and committed staff who consistently give above and beyond in delivering the best possible advocacy, policies, media, and services on behalf of our members. The AMA has a significant influence on the health of Australians – its leadership of the medical profession should not be underestimated.

Anne Trimmer
Secretary General

3.

Chair of Board Report

The AMA Board has continued its work in strengthening the governance, finances, and risk management of the company and its subsidiary companies.

I would like to thank my fellow directors for their contribution over the year and recognise in particular the outstanding work of the Investment Committee – Dr Gary Speck (Chair), Dr Elizabeth Feeney, and Professor Geoff Dobb. The Investment Committee has carried the responsibility for all aspects of due diligence on the sale of AMA House and regular liaison with the company's external independent investment advisors.

The other committees of the Board – the Audit and Risk Committee and the Nominations Committee – have also been active during the year. Key among its activities, the Audit and Risk Committee has developed a fraud control plan and a whistleblower policy for the company. The Committee has considered a risk appetite statement to be adopted by the Board in early 2018.

The Nominations Committee commenced the process in late 2017 to manage the search for the next Secretary General/CEO. Working with an external executive search consultant, the Committee is undertaking one of the most important responsibilities of any board.

The financial results for the year are solid with a similar result forecast for 2018 (leaving aside the proceeds from the sale of AMA House). Notwithstanding this result, the Board remains vigilant in reviewing expenditure, recognising that the major source of revenue is from member subscriptions.

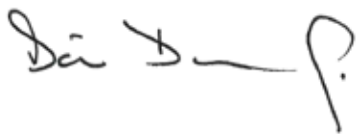
Dr Iain Dunlop AM
Chair

The broader AMA family works together for the benefit of our members.

In October, the Board undertook its three year strategic planning to map the priorities for the company and its subsidiaries for the next three years. The strategic plan 2018-2020 comes into effect on 1 January 2018, with the Secretariat developing an operational plan to deliver on the Board's strategic objectives. A major area of focus in the development of the plan was on the way in which the broader AMA family works together for the benefit of our members.

Following the Annual General Meeting in May 2017, there were two changes in the composition of the Board. Dr Richard Kidd stepped down and was replaced by Dr Chris Zappala, and Dr Peter Beaumont was replaced by Dr Danika Thiemt. I would like to thank the retiring directors for their contributions.

I would like to particularly thank the senior staff who have worked closely with the Board during the year – the Secretary General, Anne Trimmer, the Group Finance Director, Irene Quah, and the Director Member Services, Annabel Reid. On behalf of the Board, I thank all members of our Secretariat who have contributed to our organisation's strength and success in its many and various activities.



Dr Iain Dunlop AM
Chair

4.

Board Members

From left to right: Dr Gary Speck, Dr Elizabeth Feeney, Dr Bavahuna Manoharan, Dr Richard Kidd, Prof Geoff Dobb, Dr Michael Gannon, Dr Peter Beaumont, Dr Iain Dunlop, Dr Tony Bartone, Dr Peter Sharley, Dr Helen McArdle

Absent: Dr Danika Thiemt, Dr Christopher Zappala

Dr Iain Dunlop AM

MBBS (Hons), FRANZCO, FRACS, FAMA

Chair
Ophthalmologist

Dr Michael Gannon

MBBS, MRCPI, FRANZCOG, GAICD, FAMA

President, AMA
Obstetrician and Gynaecologist

Dr Anthony Bartone

MBBS, FRACGP, MBA, FAMA

Vice President, AMA
General Practitioner

Prof Geoffrey Dobb

BSc (Hons), MBBS, FRCP, FRCA, FANZCA, FCICM, FAMA

Investment Committee member
Intensive Care Physician

Dr Elizabeth Feeney

MBBS, MHL, FANZCA, FAICD, FAMA

Investment Committee member
Anaesthetist

Dr Bavahuna Manoharan

BSc (BioMed), MBBS, GAICD

Audit and Risk Committee member
Radiology Registrar

Dr Helen McArdle

BMedSc, MBBS, MPH, FAFOEM, FRACMA, FAICD

Audit and Risk Committee Chair
Specialist Medical Administrator and Occupational Physician

Dr Peter Sharley OAM

MBBS, DipObsRACOG, PGDipAvMed, DipBusMgmt, GAICD, FANZCA, FCICM, FAMA

Intensive Care Specialist

Dr Gary Speck AM

MBBS, BMedSc (Hons), FRACS, FAOrthA, FAMA, GAICD

Investment Committee Chair
Orthopaedic Surgeon

Dr Peter Beaumont

MBBS, MRACGP, FAMA

Audit and Risk Committee member
General Practitioner
(Board member to May 2017)

Dr Richard Kidd

BHB, MBChB, DipObs, FAMA

General Practitioner
(Board member to May 2017)

Dr Danika Thiemt

MBBS MPH DCH

Emergency Medicine Registrar
(Board member from May 2017)

Dr Christopher Zappala

MBBS (Hons), GAICD, GCAE, AMusA, MHM, MD, FRACP

Thoracic and Sleep Physician
(Board member from May 2017)

5.

Advocacy

Above left: Above left: Minister for Indigenous Health Ken Wyatt with the Indigenous Health Taskforce
Above Right: Opposition Leader Bill Shorten addresses AMA Federal Council
Right: Dr Gannon and Health Minister, Greg Hunt visit a general practice in the Minister's electorate of Flinders

Top left and middle: Dr Bartone and Dr John Zorbas launch the AMA Safe Hours Audit
Top right: Dr Gannon answers questions on the 2017-18 Federal Budget
Left: Dr Gannon meets with Shadow Health Minister Catherine King

Top: Dr Gannon meets marriage equality advocates Senator Dean Smith and Magda Szubanski
Right: Dr Gannon meets with Peter Dutton, Minister for Home Affairs and Minister for Immigration and Border Protection
Below: Dr Bartone and Dr Gannon with Prime Minister Malcolm Turnbull at the 2017 AMA National Conference in Melbourne

Top: Dr Bartone celebrates Family Doctor Week with the AMA Council of Doctors in Training

Centre left: Dr Gannon meets with Health Minister Greg Hunt

Left: AMA Presidents and Vice Presidents from every State and Territory mark Close the Gap Day at Winnunga Nimmityjah health clinic in Canberra

6.

Media Reach

Facebook

Australian Medical Association

305
Facebook posts

13,216
Total fans

4,113,388
Impressions

Twitter

@ama_media

17,234 Followers

1,251 Tweets

4,382,702 Impressions

@amaausmed

4,308 Followers

253 Tweets

347,236 Impressions

@amapresident

15,554 Followers

823 Tweets

3,495,379 Impressions

218 **Media releases and transcripts**
were distributed by the AMA in 2017

7.

Year in Review

Left: Dr Gannon in the ABC Radio National studio at Parliament House
Below: AMA and ASMOF agreement signing

AMA in new push for 'yes' vote on marriage

Adam Gartrell
Health Correspondent

The nation's most powerful doctors' group is ramping up its campaign for same-sex marriage despite an internal conservative backlash, with seven former Australian Medical Association bosses joining the cause and urging a "yes" vote on health grounds.

The AMA officially backed the reform in May after a 14-year debate and now intends to take an active role in the postal survey campaign, starting with its first marriage equality "doctors' rally"

Owler – are all now lending their weight to the campaign, recording messages of support and declaring that ending discrimination is "a health issue".

Dr Glasson is a former Liberal candidate who was denied a seat in Federal Parliament partly because of his support for same-sex marriage.

He was frontrunner to fill a casual vacancy in the Senate in 2015, but lost out to the more conservative Joanna Lindgren after same-sex marriage became an issue in the race.

Dr Glasson – who laments the

here and he's certainly out of touch with young Australian people. But I reckon if his sister can't convert him on this than I certainly can't.

"For me, it's a no-brainer. It'll come in anyway. I appeal for people to vote yes."

The AMA's position paper earlier this year said excluding same-sex couples from marriage had significant mental and physical health consequences and contributed to high suicide rates in the gay community.

Dr Brand, who was AMA president from 1998 to 2000, said: "Doctors work their entire lives to keep

Top: A/Prof Kelvin Kong, Warren Snowdon MP, Dr Gannon, and Indigenous Health Minister Ken Wyatt launch the AMA Indigenous Health Report Card

Centre left: Dr Gannon interviewed via satellite on Lateline

Left: Dr Gannon attends the British Medical Association conference in Bournemouth, UK
Below: AMA Future Leaders program in Canberra

Above: Past Presidents of the AMA lead a rally of doctors in support of marriage equality in Sydney

Right: Dr Gannon delivers the National Press Club Address


The Daily Telegraph
WE'RE FOR SYDNEY
05
Patients dying in wait for surgery
2017
PUBLIC HOSPITAL REPORT CARD

Top: Dr Gannon and AMA NSW President Dr Brad Frankum launch the AMA Public Hospital Report Card in Sydney

Top: Dr Gannon attends the World Medical Association meeting in Chicago, USA
Left: Dr Gannon on ABC 730
Below left: Dr Gannon meets with the TGA

8.

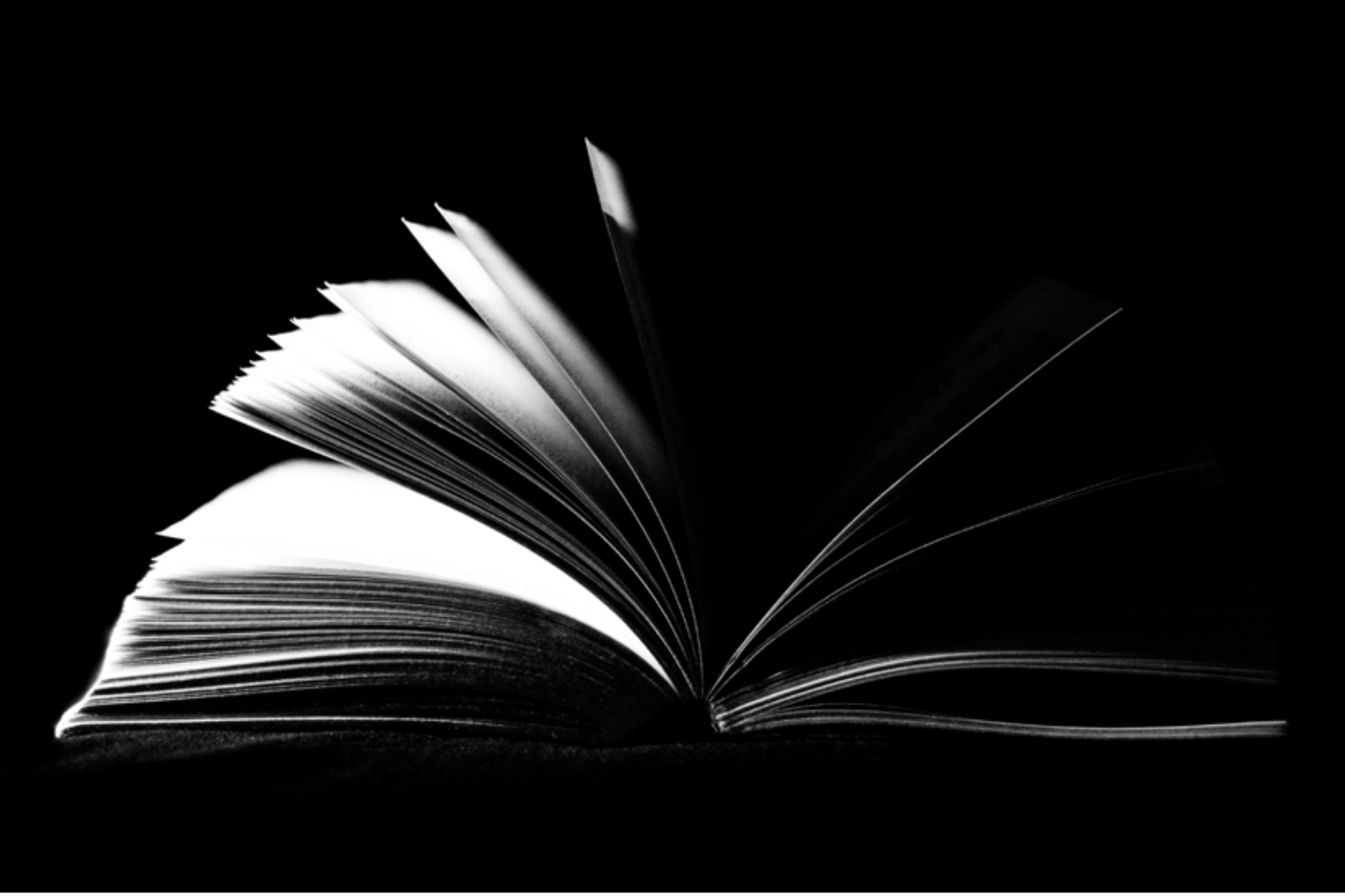
General Practice, Legal Services, and Workplace Policy

During 2017, the AMA revised or developed the following Position Statements:

- *General Practice Accreditation - 2017.*
- *Rural Workforce Initiatives - 2017.*
- *10 Minimum Standards for Communication between Health Services and General Practitioners and Other Treating Doctors - 2017.*
- *Building capacity for clinical supervision in the medical workforce - 2017.*
- *Employment of generalist medical practitioners - 2017.*
- *The role of the AMA in trainee disputes with Colleges - 2017.*
- *Prevocational medical education and training - 2011. Revised 2017.*
- *Pre-internships in medical school - 2017.*
- *Best practice in assessment for vocational trainees – 2017.*
- *Hospitalists and Non-Vocational doctors - 2017.*

In addition, as part of regular policy audits, the AMA reviewed a number of Position Statements to ensure that their content remained contemporary and continued to reflect the Association's policy stance:

- *Clinical Indicators 2012 (Reviewed 2017).*
- *Involvement of GPs in Disaster and Emergency Planning 2012 (Reviewed 2017).*
- *Supporting GPs in the Aftermath of a Natural Disaster 2012 (Revised 2017).*



Reports/Surveys

- Primary Health Networks survey.
- Interim and final reports of the National Forum on Reducing Risk of Suicide in the Medical Profession jointly convened by the AMA and Doctors' Health Services Pty Ltd.
- 2017 AMA Trainee Forum: Summary and outcomes.
- AMA Safe Hours Audit Report.

Submissions

- Independent Review of Health Providers' Access to Medicare Card Numbers.
- Senate Standing Committee for Finance and Public Administration Inquiry into circumstances in which Australians' personal Medicare information has been compromised and made available for sale illegally on the "Dark Web".
- Productivity Commission's draft report on the Telecommunications Universal Service Obligations.
- Joint Standing Committee's Inquiry into the rollout of NBN.
- RACGP Standards for after hours GP services.
- Department of Health consultation on the redistribution of medical school places.
- Department of Immigration and Border Protection on changes to temporary migration visas.

- Australian Medical Council (AMC) review of accreditation of the education and training programs provided by the:
  - Royal Australasian College of Surgeons.
  - Royal Australasian College of Dental Surgeons.
  - Australasian College of Dermatologists.
  - Australian College of Rural and Remote Medicine.
  - Royal Australian and New Zealand College of Psychiatrists.
  - Australasian College for Emergency Medicine.
- Independent Hospital Pricing Authority (IHPAs) public consultation on the:
  - Development of the Australian Teaching and Training Classification (ATTC).
  - ATTC Draft User Manual.
  - National Best Endeavours Data Set (NBEDS) Technical Specifications for Reporting.
- Review of the AMC Standards for Assessment and Accreditation of Primary Medical Programs.
- Medical Board of Australia (MBA) consultation on the Scope of a National Medical Training Survey (NTS).
- Commonwealth Government's consultation paper, *Options to reduce pressure on private health insurance premiums by addressing the growth of private patients in public hospitals*.
- Consultation on potential reforms to the Safety, Rehabilitation & Compensation Act (Cth.) 1988.

Key advocacy wins during 2017

- **Medicare card access** – the AMA ensured a proportionate response from the Government in response to concerns over the security of Medicare card numbers, avoiding more draconian proposals that would have added to the compliance burden on practices, and added a barrier to care for patients.
- **Health Care Homes** – AMA advocacy saw the Government delay the commencement of its Health Care Homes Trial and has also ensured that out of pocket costs for enrolled patients will count towards the Medicare Safety Net.
- **After-hours GP services** – the AMA led the development of reforms to after-hours GP services provided through Medical Deputising Services (MDSs) to ensure that these services are better targeted and there is stronger communication between an MDS and a patient's usual GP.

- **ACCC Authorisation** – the AMA secured a draft decision from the Australian Competition and Consumer Commission to renew the AMA's existing authorisation that permits GPs to engage in intra-practice price setting, potentially saving GPs thousands of dollars annually in legal and other compliance costs.
- **PIP Digital Health Incentive** – AMA advocacy ensured that general practices that could not meet their Shared Health Summary (SHS) target for technical issues outside their control, or that had genuinely tried to meet the target, had the option to appeal against the loss of this incentive.
- **Pathology Collection Centre Rental Reform** – Following strong representation from the AMA, a proposal to change existing prohibited practices laws was abandoned in favour of a compliance-based approach to addressing concerns over egregious rental arrangements.
- **Rural Generalist Training Pathway** – The AMA has long advocated for the establishment of a national rural generalist pathway, which is now much closer to fruition following the appointment of a National Rural Health Commissioner who has been tasked to progress the development of the pathway.
- **Regional Training Hubs** – The AMA first floated the concept of Regional Training Networks in 2014 and, following sustained advocacy, the Government announced funding for 26 regional training hubs across every State/Territory.
- **Doctors' Health** – The AMA, through its subsidiary company Doctors' Health Services Pty Ltd (DrHS) continued to consolidate accessible and consistent doctors' health advisory and referral services across the country, working closely with existing State-based services, using funding from the Medical Board of Australia.
- Federal Health Minister Greg Hunt announced in May that the Government would invest in mental health programs for doctors. The AMA is part of the consortium formed to lead work on a project that will utilise this funding.
- **Support for Indigenous trainees and doctors** – Working in collaboration with the Australian Indigenous Doctors' Association (AIDA), the AMA helped secure funding for a two-year project through the National Medical Training Advisory Network (NMTAN) that will see AIDA leading a group looking at pathways for Aboriginal and Torres Strait Islander doctors into specialist medical training.
- **National Training Survey** – The Medical Board of Australia and the Australian Health Practitioner Regulation Agency (AHPRA) announced they would lead the development and implementation of a National Training Survey (NTS). The AMA sits on the Steering Committee and Working Group for this project.
- **Rights of Private Practice in Public Hospitals** – The AMA successfully argued against potential reforms to private practice arrangements in public hospitals that would have reduced the level of funding available to public hospitals and impacted on patient choice.
- **Workplace Safety** – The AMA successfully opposed the withdrawal of *Australian Standard 4485 : Parts 1 and 2 1997 - Security for healthcare facilities*, and is now represented on a technical working group that is revising and updating this Standard to ensure healthcare workers are better protected from the risks of occupational violence.

9.

Medical Practice

Private Health Insurance

The AMA has engaged extensively with the Government on the importance of Private Health Insurance, and the need to ensure the reforms being led by the Private Health Ministerial Advisory Committee (PHMAC) put value back into private health insurance for both patients and doctors.

Through representation on PHMAC, as well as its many subcommittees on consumer information, second tier and default benefits, clinical terminology and out of pockets, the AMA has highlighted that, without a strong private health system, the public system would buckle.

The AMA has continually highlighted that the profession has worked to maintain high levels of no and known gaps. A significant amount of services provided in-hospital are at a no-gap or known-gap rate (86.6 per cent and 6.5 per cent respectively).

In addition, the AMA prepared a detailed submission to the Senate Committee inquiry into Private Health Insurance and Out-of-Pocket Costs, with the President later appearing in front of the Committee. This submission and appearance also built upon the AMA's detailed submission to the ACCC on Private Health Insurance.

The AMA welcomed the announcement that future health insurance policies will be classified under Gold, Silver, and Bronze, and require consistent clinical terminology. The AMA continues to call for improved levels of coverage, fewer restrictions, caveats and carve outs, and greater value.

In addition, the AMA produced a strong submission on the importance of the rights of private practice in public hospitals, calling for the Government to ensure that any policy change does not adversely impact patient choice.

Private Health Insurance Report Card

The AMA has released its second AMA Private Health Insurance Report Card – providing consumers with clear, simple information about how health insurance really works.

The Report Card highlights that there are a lot of policies on offer and that these provide significantly varying levels of cover, gaps, and management expenses.

The Report Card provides an example of a common item – to demonstrate what insurance may cover, what the MBS covers, and what an out-of-pocket fee may be under different scenarios.

But it also highlights that private health insurer benefits vary significantly between policies and insurance companies.

Benefits vary by State, and in 2017 we highlighted the percentage of hospital charges covered by State and fund – to help the consumer better understand what they are buying.

The 2017 Report Card also highlighted the percentage of services with no-gap by State, and what each of the funds has reported they spend on management and administration compared to what they pay out as benefits to patients.

The report showed that we need private health insurance to be simplified, we need it to be more transparent, but we need it to also cover the real costs of treatment – including the theatre fees, equipment, consumables, hospital costs, and staff time - rather than simply pointing the finger at the doctor or pushing increased out-of-pockets onto patients.

Medical Indemnity

The AMA has lodged a number of submissions to the review into the Indemnity Insurance Fund (IIF) and each of the schemes that comprise the IIF – known as the Medical Indemnity scheme. This has been backed by extensive lobbying on the importance of these schemes to both patients and the profession.

The AMA has strongly argued that any review of the schemes must have as a key outcome the long-term financial sustainability of the market for medical indemnity insurance and, through this, provide certainty to medical practitioners as to the adequacy and availability of ongoing cover.

We also argued that another key consideration in this review must be that these schemes are really a system to support compensation for patients, and that affordable indemnity insurance is directly related to affordable health care.

While the review is ongoing, the AMA will continue to work with the Department to ensure the focus remains on the administration of the schemes, and that any changes are not detrimental to practitioners. This includes coordinating with a number of the other groups who were responding to the consultation (Colleges, Associations, Societies, and Indemnity Insurance providers) to ensure some alignment of concerns and messaging. A further media release was also distributed regarding the review.

Annual Meeting of Colleges, Associations, and Societies

The AMA brought together 75 representatives from Medical Colleges, Associations, and Societies in March to update them on Government reviews into Private Health and the Medicare Benefits Schedule.

The doctors and other representatives met at AMA House in Canberra and represented a full range of specialty groups.

Chair of the Private Health Ministerial Advisory Committee, Dr Jeff Harmer AO, addressed the gathering, stating that the medical profession should take a leadership role in helping to control out-of-pocket expenses, which are a growing concern to private health insurance customers.

The AMA has been advocating for a long time that the private health insurance product was too complicated and the value evaporates as patients find that, at their time of need, their insurance does not cover services that they thought were covered. The consumer survey found that not paying benefits was of great concern to consumers.

Medicare Benefits Schedule Taskforce Review Chair, Professor Bruce Robinson, also provided an update to the meeting on the progress with the MBS Review.

Discussion from the floor covered a full range of issues over the course of an hour. The medical profession expressed concern with how some of the reviews had operated to date, and called for greater consultation on the details with the profession and the Colleges, Associations, and Societies.

The AMA then held a separate meeting with a select number of Colleges, Associations, and Societies regarding the issue of out-of-pocket costs, discussing the increasing media focus and growing commentary on the issue, and the newly formed expert committee on transparency discussed above.

Professional Performance Framework

The AMA argued strongly on behalf of the profession that proposed revalidation was inappropriate and needed to be rethought as it was too heavy handed and problematic. The AMA has argued strongly against introduction of the UK-style model, which has proven to be onerous, costly, and complex, and must be undertaken by every single registered medical practitioner on a five-yearly basis.

While recognising the value of introducing extra measures to improve patient safety, the AMA has urged instead the adoption of an approach that builds on the many systems already in place that support doctors in delivering high quality care. Australian doctors already practise in a highly regulated environment.

After a lengthy consultation process, the Medical Board announced it had designed a new *Professional Performance Framework* aimed at ensuring 'that all registered medical practitioners practise competently and ethically throughout their working lives'. The Framework replaces the Board's original revalidation proposal.

The Framework will be implemented progressively, with some components, such as CPD, already largely in place, and other components, such as the regular review of doctors aged 70 and over, needing further consultation and development.

The new model is a vast improvement over the previous proposal. The AMA will continue to work with the Medical Board of Australia and AHPRA to ensure that the model is implemented in a way that continues to promote patient safety, while not creating an unnecessary burden on the profession.

TGA Reform Agenda and Medicines

The AMA lodged 20 submissions with the Therapeutic Goods Administration (TGA) in 2017 on a wide range of medicines and devices, and regulatory and safety issues.

Many of the submissions arose from the Government's decision to implement nearly all the recommendations of an independent review on medicines and devices conducted in 2015-16. These included reforms such as fast-track approval options for potentially life-saving new medicines; changes to medicines advertising regulations; and measures to bring Australian regulatory practices into line with international standards.

AMA engagement also focused on medicines scheduling issues. The AMA lodged submissions opposing proposals from pharmaceutical companies that would allow Vardenafil, Sildenafil and Orphenadrine to be purchased over-the-counter without a prescription. The TGA subsequently denied these proposals.

All submissions were based on the advice of the Medical Practice Committee, the AMA Council of General Practice, and existing AMA policy, and are published on the AMA's website.

Scopes of Practice – Maternity Framework, Optometrists, Nurses

The AMA continued to be vigilant in ensuring patient safety is not compromised by non-medical health professionals expanding their scope of practice beyond their training and expertise.

The AMA successfully lobbied against a National Maternal Services Framework being adopted by State and Territory Governments, which failed to recognise the central role of medical practitioners in the care of women and their babies. The fact is that obstetrician-led maternity services provide the best outcomes for mothers and babies, and midwives must work within these collaborative models.

Midwives and nurses are also seeking to expand their scope of practice through independent prescribing. The AMA values the expertise and contribution of nurses and midwives in providing health care services and caring for patients, but independent prescribing by non-medical health professionals is a risk to patient safety.

The AMA lodged a submission to the Nursing and Midwifery Board of Australia, which supported collaborative models of health care in which nurses and midwives only prescribe within their scopes of practice in a medically-led and delegated team environment.

The AMA also lodged a submission to the Optometry Board of Australia calling for the continued approval by the Australian Health Workforce Ministerial Council of the list of specific Schedule 4 medicines that an optometrist holding a scheduled medicines endorsement is qualified to prescribe. This maintains additional scrutiny at the highest level of any changes to the list of S4 medicines within an optometrist's scope of practice.

Mandatory Reporting

The AMA has strongly lobbied for a change to mandatory reporting laws. In the submission to the review of the mandatory reporting provisions, the AMA calls for the adoption of the Western Australian provisions as a suitable, consistent model for doctors seeking treatment for mental health and other health conditions.

The current mandatory reporting provisions put both doctors and patients at risk by preventing practitioners from seeking medical treatment. The AMA has advocated that, like any other patient in Australia, medical practitioners deserve equal access to medical treatment. This means every health practitioner should have the confidence to access medical care and treatment in a timely way so that health conditions are diagnosed and managed early.

The AMA has also lobbied the broader medical and health professions seeking support of the Western Australian model, through messages, media releases, and representation with the Health Minister. At the time of writing, it is understood that COAG is moving towards accepting a change to the mandatory reporting laws to remove the current disincentive to seeking help.

Chair of the Medical Board

The AMA, with other regulated professions, has successfully defeated, for the time being, the proposal to appoint a non-practitioner as the Chair of the Medical Board. The provision that would have allowed the Ministerial Council to appoint a community member as Chairperson of a National Board has been removed from the Bill that was introduced into the Queensland Parliament earlier this year.

We have strongly opposed this proposed provision from its inception, and again reiterate our opposition to it being included in any future Bills.

Codeine Communication

The AMA mounted an intensive campaign to correct public misinformation and scaremongering by pharmacy stakeholders after the TGA announced that all codeine products would be moved to prescription-only from 1 February 2018.

The TGA's decision on codeine was based on the advice of pharmacist and medical experts, scientific evidence, and concerns for public safety. The AMA believes it is essential that the independence and transparency of the TGA is not undermined by political interference and sectional interests.

As well as participating in media interviews, the AMA collaborated with the TGA and non-government consumer and health professional organisations to develop definitive advice and resources to help health professionals and members of the public transition to alternative, safer pain relief options. These organisations included Pain Australia, the Consumers' Health Forum, the Society of Hospital Pharmacists of Australia, NPS MedicineWise, and the Royal Australian College of General Practitioners.

MBS Reviews

The AMA responded to every single MBS review consultation in 2017, raising issues from across the membership and stressing where systematic improvements in the entire review process are needed.

The submissions, which were lodged with the Health Minister and the Chair of the MBS Review Taskforce, highlighted a number of clear deficiencies and significant variations in the process adopted by the MBS Review Taskforce and the Clinical Committees – many of which introduce arbitrary restrictions and put practitioners at risk of compliance issues. The AMA has always insisted the MBS Reviews must be clinician-led, requiring early engagement of the relevant College, Association, and Society (CAS) groups to ensure the recommendations are practical and consistent.

As well as collaborating with the broader medical CAS groups, the AMA Secretariat and the President made further representations to the Health Minister, the Government, and the Department of Health, pressing for a review approach that is transparent and not merely a cost-cutting exercise or a mechanism that meddles with clinical decision making.

The Government has committed to working with the AMA to deliver on agreed recommendations arising from the MBS Review in conjunction with the broader profession.

In addition, the AMA undertook extensive lobbying to address changes to the MBS Skin items, which were the result of a review of the MBS items, and inappropriate Private Health Insurance banding being applied. The outcome of this was a communication sent to all insurers to ensure that doctor certification forms for PHI coverage were accepted.

MBS Compliance

The AMA participated as a key stakeholder in the Department of Health's Provider Benefits Integrity Division (PBID) consultations to revise Medicare provider compliance processes.

The consultations examined the incentives, pressures, and claiming patterns of each medical professional grouping to enable a more strategic and tailored approach to compliance interventions. In participating at the stakeholder meetings, the AMA provides advice on appropriate interventions ranging from provider education, behavioural interventions/targeted letters, audit, professional review, and fraud investigations.

The AMA lodged a submission to the PBID outlining support for new recommendations that hold corporate medical entities liable for incorrect claiming on an individual practitioner's behalf.

The AMA attended consultation meetings for general practice, pathology, and dental, and continues to work with the PBID on their revised compliance strategy throughout 2018.

MBS Freeze

The AMA continued strident lobbying for the Government to lift the Medicare Benefits freeze, which has been cutting significant funds out of the health system since its implementation in 2014.

Finally, a staggered freeze lift was announced in the May Federal Budget, starting with bulk billing incentives for GP consultations from 1 July 2017. Unfreezing of standard GP consultations and other specialist consultations will commence from 1 July 2018, procedures from 1 July 2019, and targeted diagnostic imaging services from 1 July 2020.

The AMA would have preferred to see the Medicare freeze lifted across the board from 1 July 2017, but acknowledges that the three-stage process will provide GPs and other specialists with certainty and security about their practices.

AMA advocacy also saw the reversing of proposed cuts to bulk billing incentives for diagnostic imaging and pathology services; the scrapping of proposed changes to the Medicare Safety Net that would have penalised vulnerable patients; the delaying of the introduction of the Health Care Homes trial until October to allow fine-tuning of the details; the moving to an opt-out approach for participation in the My Health Record; and recognising the importance of diagnostic imaging to clinical decision-making.

The lifting of the freeze came out of a landmark compact with the AMA and the Government with both parties committing to principles that support a stronger health system, which recognises the value and role of Medicare, the importance of sustainably funded public hospitals, the contribution made by preventive health, and acknowledges a shared interest in ensuring the strengthening and sustainability of the health system.

AMA Fees List

In October, the AMA launched the new Fees List online.

The new website replaced the *AMA List of Services and Fees* book and CD-ROM formats, making it faster and more user-friendly than ever before. Members are still able to download PDF and CSV files, plus access a range of new, useful features including:

- Interactive dashboard to find, search, and save AMA fees.
- Search function that links directly to AMA and MBS item descriptions.
- Personalised user dashboard with options to store favourite items.
- Fee calculator tools, including a new Anaesthesia calculator.
- Ability to print parts, or full PDFs, of the Fees List.
- Online tutorials and help tools.
- Mobile and tablet compatibility.
- Online payment gateway for non-members.

All financial members continue to have free, unlimited access to the Fees List website from https://feeslist.ama.com.au/

Public Hospital Funding

The AMA maintained its strong advocacy on public hospital funding throughout 2017, using the data published by the Australian Institute of Health and Welfare to produce the 2017 edition of the AMA Public Hospital Report Card. The AMA Report Card is the only report that presents core measures of hospital performance in a time series. It gives a very useful insight into public hospital performance and the experiences of the AMA doctors who work in public hospitals.

Each year, the data tells the story of public hospitals under enormous pressure to meet the demand for public hospital services, and at the same time, work to improve performance levels. Public hospital patients include some of the most vulnerable Australians and the sickest.

Throughout 2017, the AMA highlighted the growing funding crisis facing public hospitals, including in the AMA President's address to the National Press Club in August 2017.

So far, the AMA has been disappointed in the Government's opportunistic use of the 'improved safety and quality' agenda to do little more than reduce the Commonwealth growth in public hospital funding year on year. The AMA also advocated for changes to the safety and quality penalties in many forums, including in submissions to the Independent Hospital Pricing Authority (IHPA) and in follow-up meetings with the Department of Health. AMA members also participated in various IHPA working groups to ensure IHPA understands the impact the current activity-based funding formula has on patients and the doctors who treat them.

My Health Record

Following the release of the AMA Position Statement on *Shared Electronic Medical Records*, the AMA continued during 2017 to work with the Australian Digital Health Agency (ADHA) to ensure the My Health Record design adds value to the clinician user experience when patient treatment data is uploaded, and when patient treatment data is accessed by the patient's treating practitioners. Multiple AMA members participated in regular ADHA steering committees, working groups, and consultations.

The possibilities offered by the widespread adoption of the My Health Record are numerous. As more and more patient records are uploaded and more providers participate, the value and benefit to patients and treating doctors should also escalate.

The earliest benefits will flow to patients and their treating doctors in situations where the patient requires urgent, unexpected emergency treatment. Access to clinical data in the patient's My Health Record will mean the treating doctors know more about that patient's clinical history than they currently would in the same situation.

Patients with complex and chronic illness will also benefit, as a single shared summary of treatments provided by each treating doctor is uploaded and made available to the full team of health professionals collectively involved in providing integrated care to the patient.

It is important, however, to be realistic about the starting point. Bedding down a highly functional My Health Record that connects seamlessly across the clinical software used by all health service providers in all health care sectors will take time. It is, however, an endeavour worth pursuing, and the benefits to patients and clinicians make it an endeavour the AMA supports.

Medicare Security

Following the sale of Medicare numbers on the 'dark web', the Government initiated a review into Medicare security. The Independent Review of Health Providers' Access to Medicare Card Numbers had the potential to add a number of significantly problematic changes to the Medicare system, that could have impacted patient access to necessary services.

The AMA made a submission to the Independent Review, as well as to a Senate Inquiry into the circumstances in which Australians' personal Medicare information has been compromised and made available for sale illegally on the 'dark web'. The AMA's submissions stressed that there should be no increase to the administrative burden on medical practitioners/practices, calling for a response proportionate to the risks. See the full submission to the Senate Inquiry here, and the full submission to the Independent review here.

The AMA's advocacy more broadly on this topic included the two above mentioned submissions, an appearance before the Senate Inquiry, and meetings with the Minister to discuss concerns on behalf of GPs. As a result, the outcome is a series of reasonable improvements to Medicare security, representing a balanced set of recommendations that should not interfere with patient access to care or impose unreasonable administrative requirements on medical practices.

Aged Care

This year, we saw the beginnings of significant aged care system review by the Federal Government and consultation with stakeholders regarding the quality of care older Australians receive. The AMA lodged four submissions regarding different aspects of the quality of aged care.

The inadequate treatment of residents at the Oakden Older Persons Mental Health Service (Oakden) sparked two reviews: the Carnell-Paterson *Review of National Aged Care Quality Regulatory Processes*, and the Senate Community Affairs References Committee on the *Effectiveness of the Aged Care Quality Assessment and Accreditation Framework.* Both AMA submissions argue that the aged care system needs an Aged Care Commission to provide a clear governance hierarchy that brings accountability to the aged care system. Further, that the aged care Accreditation Standards must be clear and specific with a strong focus on health to protect the health and wellbeing of older people.

The aged care system also must acknowledge and support medical practitioners as part of the aged care workforce, and adequately fund the recruitment and retention of appropriately trained, registered nursing staff and carers.

These workforce issues were also raised by the AMA at the Senate Standing Committee on Community Affairs' public hearing on *the Future of Australia's Aged Care Workforce* in 2016. In 2017, the report reflected the AMA's concerns with recommendations that an established Aged Care Workforce Strategy should consider the role of medical professionals in aged care, and that a minimum nursing requirement for aged care should be established. The AMA's submission is available here.

The AMA also lodged a submission to the Department of Health's *Future reform – an integrated care at home program to support older Australians.* In this submission, the AMA called for investment in aged care now, in order to produce

the foundations of a higher quality system. The AMA also raised concerns regarding the significant waiting times for older people to have an Aged Care Assessment Team (ACAT) assessment, and receive a home care package, and that older people need more support in choosing the right services for them.

The AMA also participated in market research by the Department of Health to assess the effectiveness of My Aged Care. The AMA highlighted that, currently, My Aged Care is a barrier to accessing aged care services, and that there is a lack of coordination between ACATs, doctors, staff, and service providers.

Aged Care Survey

This year, the AMA conducted its fourth AMA Aged Care Survey, which seeks feedback from AMA members on their impressions and experiences of providing medical care to older Australians. Respondents were asked to rate the importance of measures to improve access and quality of medical care in Residential Aged Care Facilities (RACFs). Respondents, similar to previous years, marked the following measures as 'urgent' and 'extremely urgent':

- Improve availability of suitably trained and experienced nurses and other health professionals (65.92 per cent)
- Increase funding to ensure medical practitioners are properly compensated for spending time away from their surgery [to visit aged care patients] (57.55 per cent)

Other highly rated 'urgent' and 'extremely urgent' measures included improved access to palliative care, specialist care, and mental health services, and reducing polypharmacy.

These high ratings of urgency for the above measures indicate that respondents believe the quality of care and access to care for older Australians is sub-par and must be addressed quickly.

10.

Public Health

The AMA's mission is to drive public health policies for a healthier and safer Australia

Public Health Position Statements

In 2017, the AMA released seven new Public Health Position Statements.

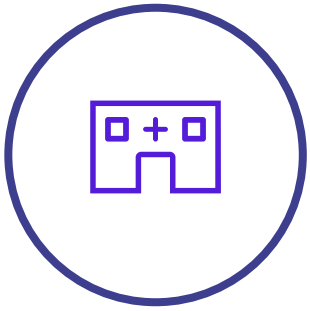
Firearms – 2017

The AMA Position Statement on Firearms had not been updated in more than 20 years. Since the implementation of the National Firearms Agreement following the tragic Port Arthur massacre, gun deaths in Australia have halved. There are still hundreds of thousands of guns held illegally in Australia, and most gun-related deaths in Australia are suicides within the families of gun owners.

It is common sense that any weapon, device, or activity that can cause death and injury is a public health issue. There is a legitimate role for guns in agriculture, regulated sport, and for the military and police, but gun possession in the broader community is a public health issue.

The revised *Firearms – 2017* Position Statement continued the AMA's call that gun ownership laws should be tightened, and a national, real-time firearms register be established. The patchwork approach in Australia needs to be tightened with real-time monitoring. The Government's gun amnesty was welcomed, but tighter regulations over storage were called for.

Firearms Working Group: A/Prof Saxon Smith (Chair), Dr Michael Gannon, Dr Chris Moy, Dr Roderick McRae, Dr Andrew C. Miller.

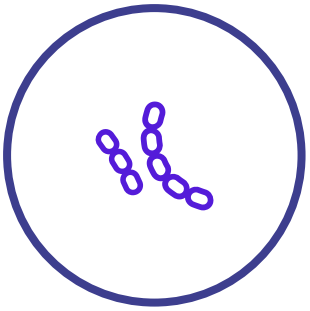


Australian National Centre for Disease Control (CDC) – 2017

Australia is the only country in the Organisation for Economic Co-operation and Development (OECD) that does not have an established national authority delivering scientific research and leadership in communicable disease control. Diseases and health threats do not respect borders. There are emerging problems with controlling communicable diseases within Australia's borders, and a CDC would provide a national focus on current and emerging communicable disease threats. Australia must join other developed nations in playing a global role in combating infectious diseases and other potential threats to the health of its people. The prevention of epidemics, pandemics, and other threats, and the capacity to conduct national responses, must be undertaken by an appropriately funded and staffed CDC.

A CDC would deliver effective communication of technical and surveillance information, and work with the States and Territories to manage the allocation of public health workforces and resources to tackle emerging and current threats. It would coordinate Australia's vital work with other countries to build international public health capacity through expanding and managing communicable disease surveillance, prevention, and control, environmental health, and health awareness and promotion.

CDC Working Group: A/Prof Rob Parker (Chair), Dr Helen McArdle, Dr Chris Zappala, Prof Robyn Langham, Dr Prashanti Manchikanti (DiT).



Blood-Borne Viruses (BBVs) – 2017

The AMA's revised Position Statement on BBVs moved away from the previous focus on clinical guidelines and testing. Instead, it calls for a greater emphasis on prevention, reliable and affordable screening, immunisation, and treatment, with stronger referral pathways, and greater investment in specialist services. Needle and syringe programs (NSPs) should be introduced in prisons and other custodial settings, to reduce the spread of BBVs, including hepatitis B and C, and HIV. Prevalence of BBVs is significantly higher in prisons, and custodial facilities provide a unique opportunity to protect the health of inmates. BBVs are a major health problem in prisons, as many people are in custody for drug-related offences.

Evidence shows that harm minimisation measures protect not just those in custody, but prison staff too. Prison-based NSP trials have been shown to reduce the risk of needlestick injuries to staff, and increase the number of detainees accessing drug treatment, while showing no adverse effect on illicit drug use or overall prison security. There is also a need for specific resourcing and management of HLTV-1, a relatively unknown BBV that affects Aboriginal people in central Australia.

BBVs Working Group: A/Prof Robyn Langham (Chair), Dr Tony Bartone, Prof Brad Frankum, Dr Helen McArdle.

Female Genital Mutilation – 2017

Female Genital Mutilation (FGM) is an unsafe and unjustifiable practice that occurs worldwide. It is estimated that approximately three million women and girls are at risk of being subjected to the practice every year. It is not clear how prevalent the practice is within Australia. The total abolition of the practice has been identified as a priority within the United Nations' Sustainable Development Goals, which Australia is committed to achieving.

There is no justification for FGM. Many proponents of the practice rationalise it as a form of religious custom, but there is no mention of the practice in any major religious doctrine. A comprehensive legislative framework prohibiting the practice is in place across all Australian States and Territories, although these laws remain relatively underutilised. The AMA Position Statement strongly condemns FGM, calling for increased efforts to prevent the practice from occurring, and a greater level of support for women and girls who have already undergone the practice.

FGM Working Group: Dr Gino Pecoraro (Chair), Dr Michael Gannon, Dr Jill Tomlinson, Prof Gary Geelhoed, Dr Sandra Hirowatari, Ms Elise Buisson (AMSA), Prof Ajay Rane.

Marriage Equality – 2017

The purpose of this Position Statement was to develop a clear position to guide the AMA's public commentary relating to marriage equality, and to highlight the health impacts of this form of institutional discrimination. The AMA believes that it is the right of any adult and their consenting adult partner to have their relationship recognised under the *Marriage Act 1961*, regardless of gender. Discrimination has a severe, damaging impact on mental and physiological health outcomes, and it is on this basis that the AMA called for the end of discrimination against Lesbian, Gay, Bisexual, Transgender, Intersex, and Queer/Questioning (LGBTIQ) Australians. LGBTIQ individuals have endured a long history of institutional discrimination. There is an undeniable link between the discrimination that LGBTIQ individuals face and the poor health outcomes that they experience.

The release of the Position Statement generated a significant response from AMA members, stakeholders, and the public. Some members raised concerns about a perceived lack of member consultation, and others expressed a view that this was outside the realm of the AMA. All members who wrote in to voice support or raise concerns regarding the AMA Position Statement received a personal response from Dr Michael Gannon. The majority of these members indicated that they were satisfied with the response they received.

Marriage Equality Working Group: Prof Brad Frankum (Chair), Dr Richard Kidd, Dr John Zorbas (DiT), Ms Elise Buisson (AMSA).

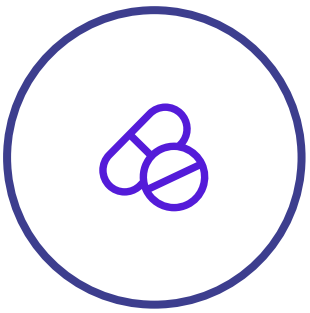
Infant Feeding and Parental Health – 2017

Breastfeeding is the optimal infant feeding method, but there is a need to balance promoting breastfeeding as the optimal choice, and supporting mothers who are unable or choose not to breastfeed. Recent trends towards shorter postpartum hospital stays mean that some women are discharged as early as 6–48 hours after delivery, before their milk has come in, reducing opportunities for hospital-based breastfeeding support. Dr Michael Gannon had spoken publicly about these concerns prior to the release of the Position Statement.

It is the AMA position that parents who are unable or choose not to breastfeed should be provided with appropriate support and assistance to formula feed their child. In addition to this, targeted breastfeeding support should be provided to populations with lower breastfeeding initiation and duration, and access to maternal and perinatal services should be improved, particularly for rural and remote, culturally and linguistically diverse (CALD), and Indigenous communities.

The AMA received a significant response following the release of the AMA Position Statement on *Infant Feeding and Parental Health,* with some stakeholders expressing concerns that the AMA position does not go far enough to emphasise the benefits of breastfeeding. The Australian Breastfeeding Association (ABA) expressed support for the AMA position. The AMA Position Statement on *Infant Feeding and Parental Health – 2017* is being used to develop Continuing Professional Development (CPD) material to assist medical practitioners in their discussions with patients around infant feeding.

Infant Feeding and Parental Health Working Group: Dr Elizabeth Gallagher (Chair), Dr Paul Bauert, Dr Chris Moy, Dr Gino Pecoraro.



Harmful Substance Use, Dependence, and Behavioural Addiction (Addiction) – 2017

Substance dependence and behavioural addictions are chronic brain diseases, and people affected by them should be treated like any other patient with a serious illness. Dependence and addiction often lead to death or disability in patients, yet support and treatment services are severely under-resourced. Being able to access treatment at the right time is vital, yet the demand for services outweighs availability in most instances.

Substance abuse is widespread in Australia. Almost one in seven Australians over the age of 14 have used an illicit substance in the past 12 months, and about the same number report drinking 11 or more standard alcoholic drinks in a single session. Substance use does not inevitably lead to dependence or addiction, but there are a number of factors that can increase or decrease the likelihood of problems, including genetic and biological factors, the age at which the use first started, psychological history, family and peer dynamics, stress, and access to support.

Those affected by dependence and addictions are more likely to have physical and mental health concerns, and their finances, careers, education, and personal relationships can be severely disrupted. The costs of untreated dependence and addictions are staggering. Alcohol-related harm alone is estimated to cost $36 billion a year.

The AMA says it is time for a mature and open discussion about policies and responses that reduce consumption, and which also prevent and reduce the harms associated with drug use and control.

Addiction Working Group: Dr David Mountain (Chair), Dr Tony Bartone, A/Prof Rob Parker, Dr John Zorbas (DiT), Dr Sandra Hirowatari, Prof Steve Kisely, Dr Ioanna Vlad.

Advocating on Public Health Issues

Indigenous Health

- The AMA released its 2017 Report Card on Indigenous Health, *A National Strategic Approach to Ending Chronic Otitis Media and its Life Long Impacts in Indigenous Communities*. This Report urged governments to address the social determinants that contribute to the persistent and ignominious health crisis that leads to permanent, disabling hearing loss and related social impacts for too many of our Aboriginal and Torres Strait Islander communities. Otitis media is caused when fluid builds up in the middle ear cavity and becomes infected. For most Australian children, it is readily treated. But for many Aboriginal and Torres Strait Islander children, otitis media is not adequately treated, leaving Australia with the highest rates of otitis media in the world. The Report Card was launched at Parliament House in Canberra on 29 November 2017 by AMA President, Dr Michael Gannon.
- The AMA Taskforce on Indigenous Health continued to provide support to the AMA President on Aboriginal and Torres Strait Islander health issues, and set the direction of the annual AMA Report Card on Indigenous Health.
- The AMA is an active member of the End Rheumatic Heart Disease (END RHD) Coalition – an alliance of organisations with a vision to see the end of RHD in Australia. Other partners that comprise the END RHD Coalition include: the National Heart Foundation, the National Aboriginal Community Controlled Health Organisation, RHD Australia, and Aboriginal Medical Services Alliance Northern Territory.
- The AMA Indigenous Medical Scholarship supports more Aboriginal and Torres Strait Islander people to become doctors. The AMA awarded the 2017 Indigenous Medical Scholarship to Mr James Chapman, an Indigenous medical student studying at the University of New South Wales. Applications for the 2018 Indigenous Medical Scholarship opened on 1 November 2017. The AMA welcomed Deakin University as its first Premier Scholarship Partner, whose generous contribution will support an Aboriginal or Torres Strait Islander medical student to realise their ambition to be a medical practitioner.
- The AMA continued to be an active member of the Close the Gap Steering Committee and to contribute to the Close the Gap Refresh Review.
- The AMA advocated for Aboriginal and Torres Strait Islander people through submissions to public consultations on key documents, including the *Australian General Practice Training Program Aboriginal and Torres Strait Islander Salary Support Program Review 2016-2017* and the National Health and Medical Research Council Road Map 3: *A Strategic Framework for Improving Aboriginal and Torres Strait Islander Health through Research*.

Obesity

Following the release of the AMA's updated Position Statement on *Obesity – 2016*, the AMA has been strongly advocating for measures to address the biggest public health challenge facing Australia.

The AMA has vigorously pursued a sugar tax on sugar-sweetened beverages; stronger controls on junk food advertising to children; improved nutritional literacy, specifically among parents and children; and encouraging increased participation in physical activity through active transport and urban design.

Dr Gannon wrote to the Minister for Health calling for serious consideration of a sugar tax, noting widespread support, related international developments, and the potential to raise revenue for the health sector. The Council of Presidents of Medical Colleges also issued a six-point plan for action on obesity, with many recommendations matching the AMA's policies.

The AMA's 2017 National Conference session, 'Tackling Obesity', which featured experts from the health and fitness sector, doctors, and the Food and Grocery Council, engaged lively discussion. It has been converted into a learning module by the AMA's Learning and Development team, and is available online through doctorportal Learning.

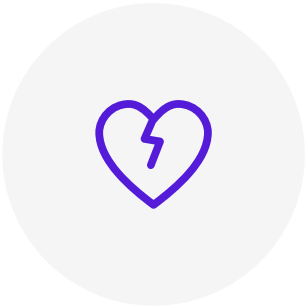
The President, Vice President, and members of the Public Heath team met with many stakeholders, including the Australian Industry Group, Food and Grocery Council, Coca-Cola, the Department of Health, and the Australian Health Policy Collaboration. The AMA continues to be closely involved with the roll out and refinement of the Health Star Rating, including representation on the Health Star Rating Advisory Committee.

Alcohol and Alcohol-Fuelled Violence

The AMA has continued to engage in a number of advocacy activities to do with alcohol and alcohol-related harm.

Dr Gannon wrote to the Minister for Health regarding the finalisation of the *2016-2021 National Alcohol Strategy (NAS)* and the dissemination of the *Australian Guide to the Diagnosis of FASD (Fetal Alcohol Spectrum Disorders)* and accompanying e-learning modules, which are an important source of guidance for general practitioners. Meetings were held with relevant stakeholders, including the Foundation for Alcohol Research and Education (FARE), and the initiators of a national pilot study, *Driving Change,* which will record the drug and alcohol intake of every patient who presents to a participating emergency department. Members of the Federal AMA Secretariat attended the *From Evidence to Action: a regional approach to changing alcohol social norms* seminar, which provided valuable insights into international responses to local alcohol problems.

Since the release of the Position Statement on *Fetal Alcohol Spectrum Disorders (FASD) - 2016*, the AMA has continued to engage in follow-up advocacy relating to FASD. Dr Gannon participated in stakeholder interviews with the Telethon Kids Institute to inform the development of the National FASD Hub, and Secretariat staff attended the strategy development workshop for the National FASD Strategy 2018-2028. The AMA continues to engage with the Telethon Kids Institute on the evolving outcomes of the Commonwealth Action Plan to reduce the Impact of FASD.



Domestic Violence

Following the release of the *Family and Domestic Violence - 2016* Position Statement, the AMA engaged with the Australian Institute of Health and Welfare (AIHW) to discuss their survey and data collection on domestic violence and the National Outcome Standards for Perpetrator Interventions (NOSPI). The AMA continues to support the Health Justice Partnership model, and meets regularly with the Law Council of Australia and Health Justice Australia on ways to reduce family and domestic violence.

Vaccination and Immunisation

Dr Gannon wrote to the Minister for Health regarding immunisation and the potential merits of a no-fault vaccine injury compensation program in Australia. The correspondence reiterated the AMA's support for the No Jab No Pay measure, but confirmed that the AMA did not support an extension of the No Jab No Play measure that could see unvaccinated children losing access to pre-school education. Dr Gannon also welcomed the addition of the quad strain meningococcal vaccine to the National Immunisation Program (NIP) for infants, following recommendations from the Pharmaceutical Benefits Advisory Committee (PBAC).

Asylum Seekers

The health care and wellbeing of refugees and asylum seekers is a continuing area of advocacy for the AMA. The AMA liaised with Doctors4Refugees and was in regular contact with International Health and Medical Services (IHMS) on specific asylum seeker health matters. Dr Gannon and the Secretary General, Anne Trimmer, met with the Minister for Home Affairs, the Hon Peter Dutton MP, to discuss the provision of health services in offshore detention facilities. The AMA is regularly contacted by asylum seekers and their advocates for assistance, and the Public Health section has engaged, where appropriate, with the Department of Home Affairs and the IHMS.

Tobacco

Tobacco and e-cigarettes continue to be a high priority for AMA advocacy. Dr Gannon wrote to all Federal Parliamentarians about the importance of a precautionary approach to e-cigarettes and the AMA's Vice President, Dr Tony Bartone, appeared alongside Professor Anne Holland and Professor Bruce Thompson from the Thoracic Society of Australia at a Parliamentary hearing into the use and marketing of e-cigarettes in Australia. The AMA also made a submission to the Parliamentary Inquiry into Vaporised Nicotine Products.

There is a diversity of views on the role of e-cigarettes in smoking cessation, as well as the potential risk to young users. The AMA position is largely guided by the National Health and Medical Research Council's (NHMRC) assessment of the evidence. The position is also consistent with a range of stakeholders, including the Public Health Association of Australia and Cancer Council Australia. The AMA continues to monitor research in relation to e-cigarettes and will review its policy position as the evidence base develops.

The AMA has also met with the Commonwealth Department of Health's Tobacco Control Branch to discuss tobacco control activities, the development of a new National Tobacco Strategy, and the need for continued focus on those population groups with higher levels of smoking. AMA Federal Council adopted a policy motion recognising the pervasive impact of nicotine on adolescent brains, and has called for further research into the merits of increasing the minimum tobacco purchasing age as one way of reducing adolescent smoking.

Prisoner Health

The AMA has approached the Federal Government and Opposition calling for a change in policy in regard to prisoners' exclusion from accessing Medicare and the Pharmaceutical Benefits Scheme (PBS). The issue of exclusion for those in custodial settings has been raised with the Commonwealth before, but there was renewed impetus for action following the Royal Commission into the Protection and Detention of Children in the Northern Territory, and also the treatment of blood-borne viruses in prison settings.

Dr Gannon co-signed a letter to the Minister for Health with Professor Stuart A. Kinner, NHMRC Senior Research Fellow, Griffith University and University of Melbourne; Mr Michael Moore AM, CEO, Public Health Association of Australia; and Professor Malcolm Hopwood, President, Royal Australian and New Zealand College of Psychiatrists (RANZCP), expressing concern that people subject to incarceration and youth detention in Australia are excluded from Medicare and the PBS. The letter urged the Minister to identify a mechanism by which this demonstrable inequity can be rectified. This exclusion disproportionately affects Aboriginal and Torres Strait Islander people, who are over-represented in custodial settings, and thus contributes to the gap in health and life expectancy for Australia's first peoples.

The Government holds the view that the provision of health care to prisoners and detained youths remains the responsibility of State and Territory governments. However, the AMA continued to advocate for this change as those in custodial facilities have greater health needs than the general population, with high rates of mental illness, chronic and communicable diseases, injury, poor dental health, and disability.

Water Fluoridation

Following the removal of fluoride from water by a number of Queensland local and regional councils, members of AMA Queensland sought Federal AMA advocacy around the importance of water fluoridation, as a public health measure.

Part of this advocacy included Dr Gannon co-signing a letter with Prof Anne Kelso, AO, CEO of NHMRC to local and regional Queensland councils. The AMA and NHMRC are unequivocal in their support for community water fluoridation. It is a safe, ethical, and proven method of improving dental and overall health. Dr Gannon also wrote to the Minister for Health, noting that water fluoridation is a key goal of the *National Oral Health Plan 2015–2024: Healthy Mouths, Healthy Lives,* and urging the development of supportive measures for those jurisdictions where local and regional councils are responsible for water fluoridation decisions.

Child Safe Organisations

The AMA participated in the consultation on the Draft National Statement of Principles for Child Safe Organisations, organised by the Australian Human Rights Commission and the Department of Social Services. The draft principles for child safe frameworks operating in Australia canvassed matters pertinent to AMA Position Statements, such as family and domestic violence, Aboriginal and Torres Strait Islander health, and child abuse and neglect. The AMA is also a stakeholder on a national coalition, managed by the Benevolent Society, which advocates for child safety and wellbeing in the family and community in order to reduce the number of children entering Out of Home Care.

Climate Change and Human Health

The AMA developed a submission for the Senate Inquiry into the *Current and future impacts of climate change on housing, buildings, and infrastructure.* The AMA submission outlines the AMA's concerns regarding the preparedness of the health care system to adapt to the challenges posed by climate change, particularly extreme heat.

The AMA Secretariat received substantial correspondence from AMA members and the public, following coverage of the closure of the Hazelwood Power Station. Responses to this correspondence reiterated the AMA's support for active transition to non-combustion energy sources.

Members of Secretariat have continued to engage with Doctors for the Environment (DEA) to ensure consistency of advocacy and met with the Wind Farm Commissioner to discuss the role of the AMA in dispelling myths regarding the adverse health impacts of wind farms. This is a space the AMA will continue to engage in as appropriate opportunities arise.

Physical Activity

The AMA continued to work with the Heart Foundation, Confederation of Australian Sport, and the Australian Health Policy Collaboration to develop a cross-sector collaboration on physical activity. Priority advocacy areas have been identified in the lead-up to the next Federal Election.

The AMA hosted a roundtable discussion with Dr Dick Telford (former Australian Institute of Sport (AIS) sports scientist and Foundation Fellow of Sports Medicine Australia), the Confederation of Australian Sport, and Dennis Yarrington, President of the Australian Primary Principals Association, to further the agenda on physical activity, specifically examining the best ways to use the primary school environment to encourage physical activity and motivate young people who do not engage in the necessary physical activity. The AMA also met with the Australian Sports Anti-Doping Authority (ASADA) about education campaigns and ways the two organisations can take a more active role in education and information sharing on sport and health issues.

Autism Spectrum Disorder

Towards the end of 2017, the Autism Cooperative Research Centre (Autism CRC) released a draft version of *The diagnostic process for children, adolescents, and adults referred for assessment of autism spectrum disorder in Australia: A national guideline*. The AMA called for the development of such guidance in the *Autism Spectrum Disorder – 2016* Position Statement. The development of the guidelines has been overseen by a Steering Committee with representation from the relevant medical colleges. The guidelines propose a two-tiered approach to diagnosis, which may reduce the time it takes for some children to receive a diagnosis, which the AMA also supports. The submission was developed in consultation with the AMA's Council of General Practice, which voiced some concern about the cost of the recommended screening tools and recent moves by some diagnosticians to refuse referrals without completed reports from teachers. The AMA's submission also referenced the need to engage with Primary Health Networks, specifically in relation to their dissemination and inclusion in Clinical Pathways, as well as the need to monitor the effectiveness of intervention.

Public Health Submissions in 2017

1. Inquiry into the delivery of outcomes under the National Disability Strategy 2010-2020 to build inclusive and accessible communities – 22 February.
2. Issues Paper on National Disability Insurance Scheme (NDIS) Costs – 31 March.
3. Development of the next iteration of the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 – 3 May.
4. FRSC Roundtable on energy labelling on alcohol beverages – 21 June.
5. Inquiry into the Use and Marketing of Electronic Cigarettes and Personal Vaporisers in Australia – 6 July.
6. Inquiry into transitional arrangements for the NDIS – 19 July.
7. Draft NHMRC Public Statement 2017: Water fluoridation and human health in Australia – 19 July.
8. Five Year Review of the Health Star Rating System – 26 July.
9. Inquiry into the Social Services Legislation Amendment (Welfare Reform) Bill 2017 – 26 July.
10. Review of the Australian General Practice Training Program (AGPT) Aboriginal and Torres Strait Islander Salary Support Policy – 27 July.
11. Inquiry into the Vaporised Nicotine Products Bill 2017 – 3 August.
12. Inquiry into current and future impacts of climate change on housing, buildings, and infrastructure – 16 August.
13. Autism CRC consultation on draft national guidelines for diagnostic process for children and adults referred for assessment of autism spectrum disorder in Australia – 21 October.
14. NHMRC Draft Road Map 3: A Strategic Framework for Improving Aboriginal and Torres Strait Islander Health through Research – 10 December.

11.

Ethics

Position Statement on Organ and Tissue Donation and Transplantation 2017

The AMA has updated its *Position Statement on Organ and Tissue Donation and Transplantation 2012* as part of the AMA's five year policy review cycle. The policy review process kicked off with the 2017 AMA National Conference Q&A session on organ donation, entitled *Improving Australia's Organ Donation Rate: Ethical and Practical Issues.*

The AMA strongly supports organ and tissue donation and encourages everyone to consider becoming a donor. In Australia, as with all developed countries, there continues to be insufficient donated organs to meet the needs of those who might benefit from transplantation.

The AMA advocates that public trust and confidence in the organ and tissue donation and transplantation system is critical for increasing donation rates. Individuals may be more willing to donate their organs and tissues if they trust the system to be fair, accountable, transparent, and safe. The Position Statement outlines how we can ensure such a system, based on an ethical framework that encompasses principles such as altruistic donation, informed and voluntary consent, respect for donation decisions, support for donor families, fair allocation of organs and tissues, and respect for privacy and confidentiality.

The updated statement establishes policy positions on a range of issues including public education and awareness, donor families, living donors, umbilical cord blood banks, allocation of organs and tissues, organ trafficking, transplant commercialism and transplant tourism, workforce and infrastructure, and quality and safety.

The updated statement continues to acknowledge the debate regarding 'opt in' vs 'opt out' models of organ donation, while not actually supporting one model over the other. The statement upholds the principle that 'either system of organ and tissue donation should be based on free, informed donor choice, involving the right to choose, as well as to refuse, to be an organ and tissue donor.'

Statistics from the Australian Donation and Transplantation Activity Report 2017, donatelife.gov.au

SINCE THE IMPLEMENTATION OF THE AUSTRALIAN GOVERNMENT'S NATIONAL REFORM PROGRAMME IN 2009:

The number of organ transplant recipients has now passed

10,000 (in 2017)

There have been

3,464

deceased organ donors since 2009

The number of deceased organ donors per year has

more than doubled,

from 247 in 2009 to 510 in 2017

The number of organ transplant recipients (from deceased donations) has

increased by 75%,

from 799 in 2009 to 1,402 in 2017

World Medical Association *Declaration of Geneva*

The AMA adopted the updated the World Medical Association (WMA) *Declaration of Geneva*, now referred to as the 'Physician's Pledge', and often considered a modern version of the Hippocratic Oath. The *Declaration of Geneva* is one of the oldest, and most defining, of the WMA's ethical statements. Established in 1947, the WMA (of which the Federal Council of the British Medical Association in Australia was a founding member) was particularly concerned with the global state of medical ethics and decided to take on the responsibility of developing ethical guidelines for the world's doctors. The WMA believed that developing an international oath, or pledge, to be recited upon graduating medical school, would impress upon newly qualified doctors the fundamental ethics of medicine and raise the standard of professional conduct.

Attempting to seek international consensus on a pledge that was relevant to, and representative of, doctors from a wide range of cultural, religious, racial, political, and linguistically diverse backgrounds, was challenging, but in 1948 the 2nd WMA General Assembly officially adopted the *Declaration of Geneva* to serve that role. Over the years, the Declaration has undergone only minor amendments, the exception being its most recent iteration. In October 2017, the 68th WMA General Assembly in Chicago adopted the 7th revision of the Declaration, a culmination of a two year consultation with over 100 member National Medical Associations, as well as the public.

The Declaration has changed in subtle, but significant, ways. It is now more patient-centred. For the first time, it refers to patient autonomy and dignity and recognises the importance of 'wellbeing' to patient care. Further, the whole document has been reformatted to emphasise obligations to patients first followed by obligations to colleagues and society.

The updated Declaration better reflects the modern notion of collegiality. While doctors should respect their teachers, it now recognises they should respect their colleagues and students as well. Particularly relevant to the Australian context, the Declaration acknowledges the essential role that physician 'wellbeing' (and not just health) has on a doctor's ability to provide a high standard of patient care. In addition, it now refers to sharing medical knowledge for the benefit of the individual patient and wider health care, recognising the duty not just to the individual but the broader health system and society.

The AMA made several submissions to the WMA throughout the process of revising the *Declaration of Geneva*, ultimately adopting the updated Declaration in November. In addition to actively contributing to the review of the *Declaration of Geneva*, the AMA also participated as a member of the WMA's Workgroup revising the WMA *Declaration on Therapeutic Abortion*.

AMA support for doctors working in conflict zones

In addition to the *Declaration of Geneva*, the AMA has formally adopted a range of WMA statements including the:

- *Declaration of Tokyo. Guidelines for Physicians Concerning Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment in Relation to Detention and Imprisonment 2016.*
- *Regulations in Times of Armed Conflict and Other Situations of Violence 2012.*
- *Declaration of Seoul on Professional Autonomy and Clinical Independence 2008.*

In keeping with the AMA's commitment to raise awareness of the role of medical neutrality and protection for health care workers in conflict zones, the International Committee of the Red Cross (ICRC) was invited to present the Health Care in Danger project to the 2017 AMA National Conference. The Health Care in Danger project is an initiative of the International Red Cross and Red Crescent Movement aimed at addressing the issue of violence against patients, health care workers, facilities, and vehicles, and ensuring safe access to, and delivery of, health care in armed conflict and other emergencies. Following on from the Conference, the AMA formally endorsed the ICRC's *Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies.*

The WMA consistently condemns governments and others who threaten to compromise professional autonomy and clinical independence, as well as those who undermine the role of medical neutrality and fail to protect health care workers in areas of armed conflict. As a member National Medical Association, the AMA has actively supported doctors working in conflict zones by raising awareness of health care in danger in areas of conflict including Bahrain, Syria, and Turkey, advocating that governments and armed combatants:

- respect medical neutrality and the duty of doctors to care for the sick and injured, impartially and without discrimination;
- allow health workers to attend the sick and injured freely, independently, and in accordance with the ethical principles of their profession, without fear of punishment, imprisonment, prosecution, or intimidation;
- ensure the safety, independence, and personal security of health workers at all times; and
- protect medical facilities and transports, and ensure that people have safe, unimpeded access to care.

The ICRC's most recent report on Health Care in Danger highlighted

2,398 incidents of violence against health care in armed conflicts and other emergencies in 11 countries between January 2012 and December 2014 (International Committee of the Red Cross. *Health Care in Danger. Violent Incidents Affecting the Delivery of Health Care. January 2012 to December 2014*. ICRC, April 2015).

The report found:

- patients were killed, wounded, beaten, and arrested;
- health care workers were threatened and physically assaulted as well as subjected to arrest, coercion, and forced treatment;
- incidents often occurred against, inside, or within the perimeter of health care facilities, the facilities often being subjected to attack, armed entry, takeover, or looting; and
- medical transports were often obstructed or attacked.

In addition to the ICRC's research, the World Health Organization (WHO) highlighted 594 attacks on health care facilities during emergencies between January 2014 to December 2015, resulting in 959 deaths and 1,561 injuries (World Health Organization. *Report on Attacks on Health Care in Emergencies. Based on Consolidated Secondary Data 2014 and 2015*. World Health Organization, 2016.)

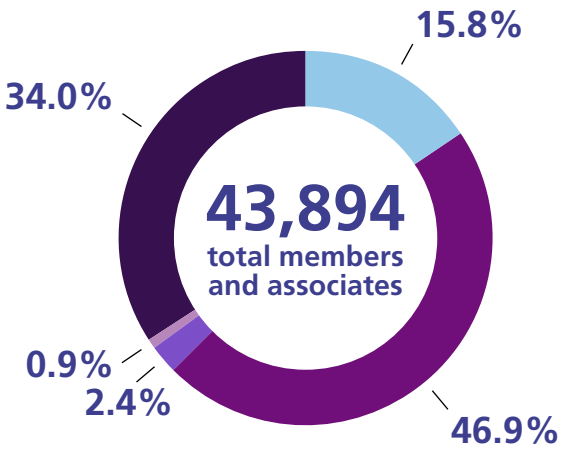
12.

Membership Services

Membership numbers

Membership by type:

Type	Members
Doctor in Training	6,937
Specialist, CMO & GP	20,565
Retired from Practice	1,050
Other, academic, administration, & study leave	400
Total	**28,952**
Associate medical student members	14,942

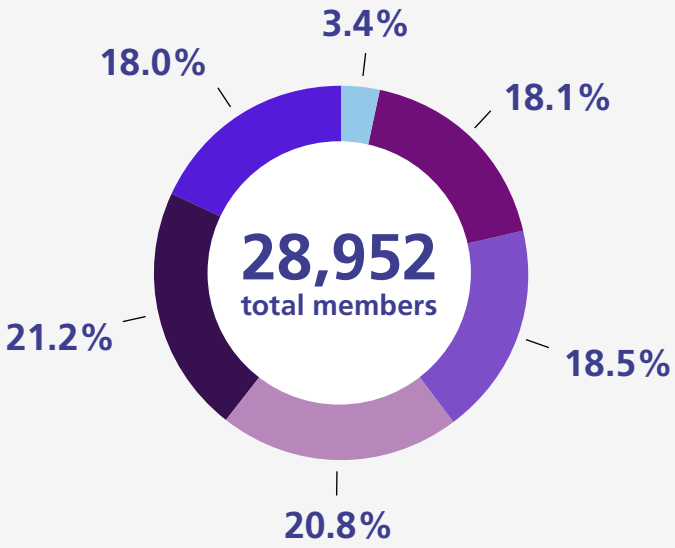


"I'm a member because the AMA is instrumental in ensuring the interests of the medical profession and its patients are foremost in an ever-changing and evolving health sphere."

Dr Eleanor Chew, GP, member of 32 years

Membership by Age

Age Group	Members
<25	995
25-34	5,234
35-44	5,348
45-54	6,022
55-65	6,138
>65	5,215
Total	**28,952**



National Conference 2017

The AMA's National Conference in 2017 welcomed delegates with a unique glimpse into medico-politics, global health, public health, and contentious contemporary health policies such as the Medicare freeze, the MBS and PHI reviews, public hospital funding, and the Health Care Homes trial.

Featured speakers included Prime Minister, Malcolm Turnbull; Health Minister, Greg Hunt; Opposition Leader, Bill Shorten; Shadow Health Minister, Catherine King; Greens Leader, Richard Di Natale; and Minister for Indigenous Health, Ken Wyatt AM.

The 2017 Conference moved beyond local politics with a range of sessions that looked at health from a global perspective. The Conference brought together a pool of experts to discuss health care delivery in areas of conflict; infectious disease threats from overseas that may cross our borders; the worldwide push to combat obesity; doctors' health and wellbeing; and lifting Australia's organ donation rates to match the world leaders.

Dr Bronwyn King, Founder and CEO, Tobacco Free Portfolios, shared her insights on leadership and advocacy at the Conference's Leadership Development Dinner. Dr King spoke passionately about her experience working towards tobacco control, which has led to a significant global shift towards tobacco-free investment.

Dr Linny Phuong, a Paediatric Infectious Disease Fellow at the Royal Children's Hospital Melbourne, was presented with the AMA Doctor in Training 2017 Award. Dr Phuong was recognised for her contributions to teaching, medical education, research, and doctors' wellbeing, as well as her professionalism and compassion towards children and their families.

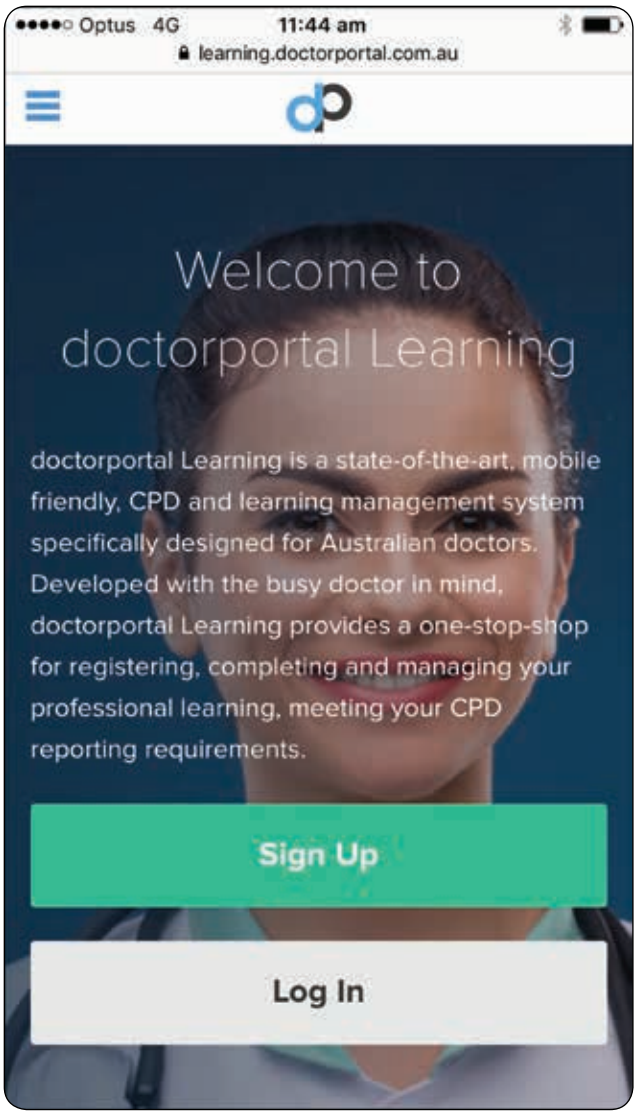
The AMA also recognised leaders in medicine through the AMA awards. Prof Bernard Pearn-Rowe, a long-serving and dedicated GP, was recognised with one of the AMA's highest awards, the President's Award.

Dr Bill Glasson AO, the AMA President who steered a course through the medical indemnity crisis in the early 2000s, was also recognised with the highest honour the peak medical body can bestow – the AMA Gold Medal.

Delegates again had the chance to network and discuss their thoughts on a particular topic during Sunday's Breakfast. Topics included managing stress in the medical profession to end of life care; rural training hubs; and more. Delegates also shared their views on improving the health system during the popular Soapbox session. On the whole, the Conference was a successful and engaging event.

doctorportal Learning

https://learning.doctorportal.com.au



doctorportal Learning provides AMA members with an online platform that supports the management of professional CPD learning and reporting obligations. This resource is absolutely free to members as a benefit of membership.

In 2017, the doctorportal Learning Catalogue was expanded to include over 100 new, online learning modules and CPD event listings. New education available in the catalogue addressed a range of clinical and non-clinical education topics, with the most popular content including:

- *MJA's ACS Guidelines* – Online RACGP, ACRRM accredited (MJA).
- *Advanced Life Support* – Australia's only virtual ALS certification (CRANAPlus).
- *Specialised clinical communications training* – Face to face event (Pam McLean Centre).
- *Suturing basics* – Online ACRRM, ACEM accredited (Osler Technology).
- *Thrombosis in Primary Care* – Online RACGP Category 1 accredited (Inspire HCP).
- *Doctors' Health & Wellbeing* – Online RACGP, ACRRM accredited (AMA).
- *Diploma of Leadership & Management* – Self-paced formal qualification, RACGP accredited (AMA WA).
- *Difficult conversations* – Online (Fair Work Ombudsman).

AMA Career Service

https://ama.com.au/careers

The AMA Career Service offers members free one-to-one medical career counselling, online career resources, workshops, and seminars.

ama.com.au/careers

The Career Service web resource has been a popular addition to the AMA website with between 800-1000 visits daily, principally from Australian visitors. The most visited resources include "becoming a doctor", the *Specialist Training Pathways Guide*, international medical graduates resources, and 'preparing for independent practice'.

One-to-one career counselling

The AMA knows that there are many medical practitioners who have never, ever had to sit an interview and, as part of a career direction change, find themselves having to update their CV, address selection criteria, and attend an interview. The AMA Career Service recognises that Doctors in Training need to gain the edge when applying for positions. The AMA Career Service is there to help members as they navigate through change in their medical career.

In 2017, the most popular services requested by members included advice on interview preparation and performance including "mock interviews", cover letter reviews, and advice (and reviews) on addressing selection criteria. Many members received assistance through consultations on how to choose a career path and which specialty might meet their needs, skills, attributes, and lifestyle choices.

In addition to helping hundreds of members, it should also be noted that 214 international medical graduates, Australians graduating overseas, or considering studying medicine overseas, have also contacted the AMA Career Service for advice.

Workshops and Seminars

In 2017, six career seminars or workshops were conducted with a total of 170 attendees, and an additional 90 attending the AMA ACT welcome to new medical students function. Workshops included:

- "*So you want to be a doctor*", for secondary school students in Darwin, in association with AMA NT.
- "*Interview skills workshop*" for DiTs in Darwin, Hobart, Launceston, and Canberra in association with AMA NT, AMA TAS, and AMA ACT.
- "*Preparing for medical practice in Australia*", a workshop for International Medical Graduates held in Canberra as an AMA Federal initiative, with 55 IMGs attending from ACT, NSW, and Victoria.

13.

Financial Report

General Purpose Financial Report
Australian Medical Association Limited and Controlled Entities
ABN 37 008 426 793
For the financial year 31 December 2017

Contents

Directors' Report

Directors

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

Dr Iain Dunlop AM
MBBS (Hons), FRANZCO, FRACS, FAMA
Chair
Ophthalmologist

Dr Elizabeth Feeney
MBBS, MHL, FANZCA, FAICD, FAMA
Investment Committee member
Anaesthetist

Dr Michael Gannon
MBBS, MRCPI, FRANZCOG, GAICD, FAMA
President, AMA
Obstetrician and Gynaecologist

Dr Anthony Bartone
MBBS, FRACGP, MBA, FAMA
Vice President, AMA
General Practitioner

Dr Peter Beaumont
MBBS, MRACGP, FAMA
Audit and Risk Committee member
General Practitioner
(Board member to May 2017)

Prof Geoffrey Dobb
BSc (Hons), MBBS, FRCP, FRCA, FANZCA, FCICM, FAMA
Investment Committee member
Intensive Care Physician

Dr Richard Kidd
BHB, MBChB, DipObs, FAMA
General Practitioner
(Board member to May 2017)

Dr Bavahuna Manoharan
BSc (BioMed), MBBS, GAICD
Audit and Risk Committee member
Radiology Registrar

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

Dr Peter Sharley OAM
MBBS, DipObsRACOG, PGDipAvMed, DipBusMgmt, GAICD, FANZCA, FCICM, FAMA
Intensive Care Specialist

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

Dr Danika Thiemt
MBBS MPH DCH
Emergency Medicine Registrar
(Board member from May 2017)

Dr Christopher Zappala
MBBS (Hons), GAICD, GCAE, AMusA, MHM, MD, FRACP
Thoracic and Sleep Physician
(Board member from May 2017)

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 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.

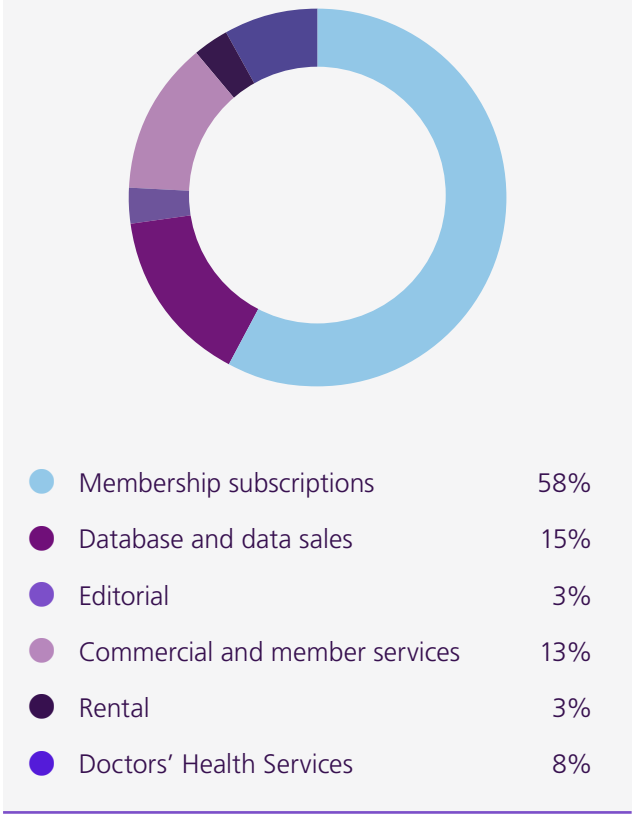
Through its subsidiary, Australasian Medical Publishing Company Pty Limited (AMPCo), it publishes the *Medical Journal of Australia*, and provides commercial database services. Through its subsidiary, Doctors' Health Services Pty Limited, it facilitates delivery of health services to medical practitioners and medical students. The consolidated Group owns property and investment assets to support revenue earned from membership subscriptions.

Financial results

Review and result of operations

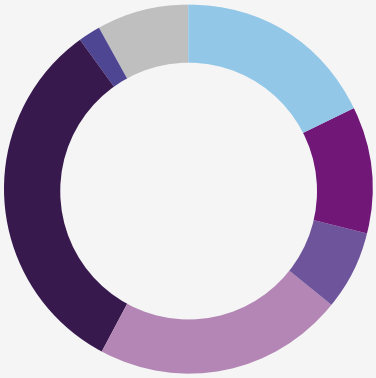
The consolidated profit after income tax was $0.3 million (2016: loss $0.6 million). The operations of the Group during the financial year included: promoting the interests of the medical profession in the medico-political arena and more widely; advocating for patient health and the health of the community; servicing members through the provision of a range of membership services and benefits; publishing, among other things, the highly recognised and peer reviewed general medical journal, the *Medical Journal of Australia*; coordinating the delivery of medical services to medical practitioners and medical students; the management and rental of commercial properties and maintenance and operation of a comprehensive database containing both member and non-member information.

Revenue



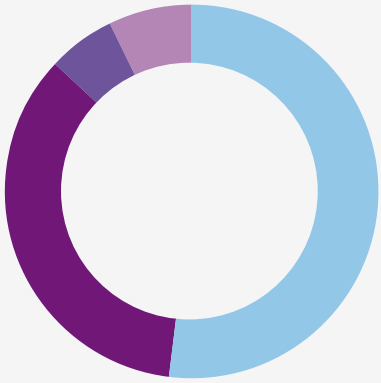
Total revenue has increased by 3.2% (2016: 4.2%) to $22.3 million (2016: $21.6 million) compared to the last financial year.

Expenses



Commercial and member services	18%
Database and data	11%
Doctors' Health Services	7%
Publications	22%
Advocacy and policy	32%
Subsidies	2%
Property	8%

Assets



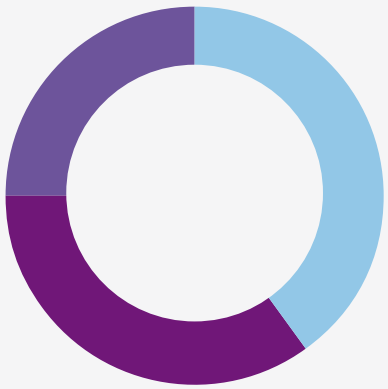
Property, plant and equipment, investment properties, and intangibles	52%
Cash and investments	35%
Receivables	6%
Other	7%

Total expenses (excluding income tax) decreased by 1.5% (2016: 6.9%) to $22.3 million (2016: $22.6 million).

Review of financial position

Net assets increased 1.3% to 19.6 million compared to prior year (2016: decrease 2.9% to $19.3 million). During the year, AMA House was made available for sale with contracts exchanged in October 2017 and settled in March 2018. As a result, the written down value of the asset is recorded as an asset held for sale as at 31 December 2017. On settlement, Australian Medical Association Limited entered into a 5 year lease agreement with options to extend, with the new owners of the building. Naming rights to the building remain with Australian Medical Association Limited.

Liabilities



Payables	40%
Employee benefits	35%
Other	25%

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 continued with the third year of its three year strategic objectives, originally adopted in late 2014 for the period 2015-2017.

The strategic objectives support the AMA's mission of *Leading Australia's Doctors – Promoting Australia's Health*.

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.

Likely developments

The company has continued its investment in IT infrastructure and solutions over the past year. This is likely to continue with new products and services for members with an emphasis on online learning.

The company will continue its advocacy on behalf of members and their patients, publishing major reports throughout the year.

In 2016, the AMA Indigenous Medical Scholarship Fund received Deductible Gift Recipient status and is registered with the Australian Charities and Not-for-Profit Commission. This has facilitated campaigns to attract donations to grow the corpus of the Fund to increase the number of scholarships available for the education of Indigenous medical students.

The Board's investment committee has worked closely with the company's external investment adviser to maximise the investment returns to the company. The investment committee has been engaged during the year on all aspects of the sale of AMA House to deliver an improved return on the use of member subscriptions.

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 115.

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 2017, 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 comprises 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. Dr Iain Dunlop was re-elected as Chair in June 2017 for a 12 month term.

Under the Constitution, the Directors are required to be appointed on the basis of their skills and experience.

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 23.

Directors meeting attendance

During the period 1 January 2017 to 31 December 2017, the Board met on 12 occasions. Five were face to face meetings, and seven were via teleconference/ videoconference.

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

The Investment Committee met 12 times, with all three members of the Committee being Directors.

The following tables summarise the meeting attendance of the Directors and Committee members during 2017, noting the number of meetings each Director/Committee member was eligible to attend; and actually attended.

Board Meetings

	Eligible to attend	Attended
Dr Michael Gannon	12	10
Dr Anthony Bartone	12	11
Dr Iain Dunlop	12	12
Dr Peter Beaumont	5	4
Professor Geoff Dobb	12	12
Dr Elizabeth Feeney	12	12
Dr Richard Kidd	5	5
Dr Helen McArdle	12	11
Dr Bavahuna Manoharan	12	10
Dr Peter Sharley	12	11
Dr Gary Speck	12	11
Dr Danika Thiemt	7	6
Dr Chris Zappala	7	6

Audit and Risk Committee

	Eligible to attend	Attended
Dr Helen McArdle	4	4
Mr Ed Killesteyn	4	4
Dr Bavahuna Manoharan	2	2
Dr Peter Beaumont	2	2

Investment Committee

	Eligible to attend	Attended
Dr Gary Speck	12	12
Professor Geoff Dobb	12	12
Dr Elizabeth Feeney	12	12

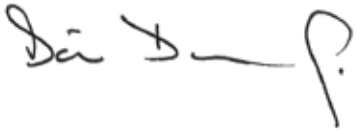
The AMA is a company limited by guarantee. If the AMA is wound up, each member of the AMA, and each person who ceased to be a member in the preceding year, undertakes to contribute to the payment of debts and liabilities and the costs, charges, and expenses of winding up the AMA, and the adjustments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

Signed in accordance with a resolution of the Directors.

Dr Michael Gannon

Director

Australian Medical Association Limited



Dr Iain Dunlop

Director

Australian Medical Association Limited

Statement of comprehensive income

For the year ended 31 December 2017

	Note	Consolidated 2017 $'000	Consolidated 2016 $'000
Revenue		**21,732**	21,147
Other income		**540**	441
	2	**22,272**	21,588
Expenses			
Employment		**(12,008)**	(12,614)
Publications		**(1,734)**	(1,714)
Database and data		**(32)**	(117)
Advocacy and policy		**(1,559)**	(1,558)
Subsidies	2	**(486)**	(493)
Commercial and member services		**(250)**	(422)
Doctors' Health Services		**(1,587)**	(933)
Property and occupancy		**(1,055)**	(1,194)
Depreciation and amortisation	22	**(807)**	(858)
Administration	2	**(2,737)**	(2,699)
		(22,255)	(22,602)
Profit/(loss) before income tax		**17**	(1,014)
Income tax credit/(expense)	4	**244**	426
Profit/(loss) for the year	22	**261**	(588)
Total comprehensive profit/(loss) for the year		**261**	(588)

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

Statement of financial position

as at 31 December 2017

	Note	Consolidated 2017 $'000	Consolidated 2016 $'000
Assets			
Current assets			
Cash and cash equivalents	5	**3,615**	4,475
Trade and other receivables	6	**1,483**	1,496
Inventories	7	**35**	38
Prepayments	8	**398**	436
Income tax receivable	16	**–**	173
Assets held for sale	17	**9,728**	–
Total current assets		**15,259**	6,618
Non-current assets			
Other investments	9	**4,540**	3,782
Intangible assets	10	**519**	100
Investment properties	11	**495**	600
Property, plant and equipment	12	**1,358**	10,934
Deferred tax assets	13	**1,260**	1,016
Total non-current assets		**8,172**	16,432
Total assets		**23,431**	23,050
Liabilities			
Current liabilities			
Trade and other payables	14	**2,483**	2,434
Employee benefits	15	**1,220**	1,165
Total current liabilities		**3,703**	3,599
Non-current liabilities			
Employee benefits	15	**133**	117
Total non-current liabilities		**133**	117
Total liabilities		**3,836**	3,716
Net assets		**19,595**	19,334
Equity			
Retained earnings		**19,595**	19,334
Total equity		**19,595**	19,334

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

Statement of changes in equity

for the year ended 31 December 2017

Consolidated	Retained earnings $'000
At 1 January 2016	19,922
Loss for the year	(588)
At 31 December 2016	19,334
Profit for the year	261
At 31 December 2017	19,595

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

Statement of cash flows

for the year ended 31 December 2017

	Note	Consolidated 2017 $'000	Consolidated 2016 $'000
Cash flow from operating activities			
Receipts from membership subscriptions		**13,553**	13,218
Other receipts from customers		**11,067**	10,806
Payment to suppliers and employees		**(24,540)**	(24,800)
Interest received		**347**	374
Interest paid		**–**	(5)
Income tax refund		**173**	722
Net cash flow from operating activities	22	**600**	315
Cash flow from investing activities			
Payments for intangible assets	10	**(471)**	(37)
Payments for property, plant and equipment	12	**(706)**	(809)
Payments for other investments		**(283)**	(3,782)
Dividends received	2, 22	**–**	1
Net cash flow used in investing activities		**(1,460)**	(4,627)
Net decrease in cash held		**(860)**	(4,312)
Cash and cash equivalents at the beginning of the year		**4,475**	8,787
Cash and cash equivalents at the end of the year		**3,615**	4,475

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

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 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 17 April 2018.

(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 21 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.

Note 1 Statement of Significant Accounting Policies (continued)

(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

The Group assesses impairment at the end of each reporting period by evaluation of conditions and events specific to the Group that may be indicative of impairment triggers.

(d) Revenue recognition

Revenue is recognised for the major business activities 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.

Database, Data sales and Editorial

Revenue from the sale of goods is measured at the fair value of the consideration received or receivable, net of returns, allowances and trade discounts. Revenue is recognised when persuasive evidence exists, usually in the form of an executed sales agreement, that the significant risks and rewards of ownership have been transferred to the buyer, recovery of the consideration is probable, the associated costs and possible return of goods can be estimated reliably, there is no continuing management involvement with the goods and the amount of revenue can be measured reliably. If it is probable that discounts will be granted and the amount can be measured reliably, then the discount is recognised as a reduction of revenue as the sales are recognised.

Commercial and member services

Revenue from commercial and member services is determined with reference to the stage of completion of the transaction at the end of the reporting period and where the outcome of the contract can be estimated reliably. Stage of completion is determined with reference to the services performed to date as a percentage of total anticipated services to be performed. Where the outcome cannot be estimated reliably, revenue is recognised only to the extent that related expenditure is recoverable. For commission-related revenue, when an entity in the Group acts in the capacity of an agent rather than as the principal in a transaction, the revenue recognised is the net amount of commission made by the Group.

Note 1 Statement of Significant Accounting Policies (continued)

(d) Revenue recognition (continued)

Doctors Health Services

Doctors Health Services relates to the administration of government funding for distribution to doctors' health program providers. Revenue is recognised on a systematic basis over the periods that the related costs, for which it is intended to compensate, are expensed.

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.

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).

(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

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.

Note 1 Statement of Significant Accounting Policies (continued)

(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.

(h) Non-derivative financial instruments

The Group initially recognises loans, receivables and deposits on the date that they originated. All other financial assets (including assets designated at fair value through profit or loss) are recognised initially on the trade date at which the Group becomes a party to the contractual provisions of the instrument.

The Group no longer recognises a financial asset when the contractual rights to the cash flows from the asset expire, or it transfers the rights to receive the contractual cash flows on the financial asset in a transaction in which substantially all the risks and rewards of ownership of the financial asset are transferred. Any interest in transferred financial assets that is created or retained by the Group is recognised as a separate asset or liability.

Financial assets and liabilities are offset and the net amount presented in the statement of financial position when, and only when, the Group has a legal right to offset the amounts and intends either to settle on a net basis or to realise the asset and settle the liability simultaneously.

Loans and receivables

Loans and receivables are financial assets with fixed or determinable payments that are not quoted in an active market. Such assets are recognised initially at fair value plus any directly attributable transaction costs. Subsequent to initial recognition, loans and receivables are measured at amortised cost using the effective interest method of asset valuation, less any impairment losses. Loans and receivables comprises cash and cash equivalents and trade and other receivables.

Available for sale financial assets

The Group's investment in equity securities are classified as available for sale financial assets. Subsequent to initial recognition, they are measured at fair value except for unit trusts that do not have a quoted market price in an active market and where the fair value is insignificant and cannot be measured reliably.

Held-to-maturity investments

Bills of exchange and debentures with fixed or determinable payments and fixed maturity dates that the Group has the positive intent and ability to hold to maturity are classified as held-to-maturity investments. Held-to-maturity investments are measured at amortised cost using the effective interest method less any impairment.

Note 1 Statement of Significant Accounting Policies (continued)

(h) Non-derivative financial instruments (continued)

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.

(i) 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.

(j) 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.

(k) 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.

(l) 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.

(m) 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.

Note 1 Statement of Significant Accounting Policies (continued)

(m) Property, plant and equipment (continued)

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:

	2017	2016
Buildings	**2.5% – 4%**	2.5% – 4%
Office Furniture	**5% – 25%**	5% – 25%
Office Equipment	**10% – 50%**	10% – 50%
Fixture and Fittings	**5%**	5%
Motor Vehicles	**12.5%**	12.5%
Personal Computer Network	**20% – 27%**	20% – 27%
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)

(n) 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.

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:

	2017	2016
Membership Database	**20%**	20%
IT Project Development Costs	**20% – 33.33%**	20% – 33.33%
Website	**20% – 33.33%**	20% – 33.33%
Computer Software	**10% – 25%**	25%

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

(o) Investment properties

Investment properties are held either to earn rental income and capital appreciation or for both, but not for sale in the ordinary course of business, use in the production or supply of goods or services or for administrative purposes. Investment property is measured at cost less accumulated depreciation and accumulated impairment losses. Direct lease costs incurred in negotiating and arranging operating leases over investment property are added to the carrying amount and recognised as an expense over the lease term.

Depreciation is calculated on a straight-line basis over the estimated useful life of the assets as follows:

	2017	2016
Buildings	**2.5% – 4%**	2.5% – 4%

Note 1 Statement of Significant Accounting Policies (continued)

(p) Leased assets

Leases of fixed assets, where substantially all the risks and benefits incidental to the ownership of the asset – but not the legal ownership – are transferred to entities in the consolidated group, are classified as finance leases.

Finance leases are capitalised by recognising an asset and a liability at the lower of the amounts equal to the fair value of the leased property or the present value of the minimum lease payments, including any guaranteed residual values. Lease payments are allocated between the reduction of the lease liability and the lease interest expense for the period.

Leased assets are depreciated on a straight-line basis over the shorter of their estimated useful lives or the lease term.

Lease payments for operating leases, where substantially all the risks and benefits remain with the lessor, are recognised as expenses on a straight-line basis over the lease term. Operating leases are not recognised in the statement of financial position.

Lease incentives under operating leases are recognised as a liability and amortised on a straight-line basis over the life of the lease term.

(q) Impairment

Financial assets

A financial asset is assessed at each reporting date to determine whether there is any objective evidence that it is impaired. A financial asset is considered to be impaired if objective evidence indicates that one or more events have had a negative effect on the estimated future cash flows of the asset.

An impairment loss in respect of a financial asset measured at amortised cost is calculated as the difference between its carrying amount and the present value of the estimated future cash flows discounted at the original effective interest rate. An impairment loss in respect of an available for sale financial asset is calculated by reference to its current fair value.

For available for sale equity instruments, including listed or unlisted shares, objective evidence of impairment includes information about significant changes with an adverse effect that have taken place in the technological, market, economic or legal environment in which the issuer operates, and indicates that the cost of the investment in the equity instrument may not be recovered. A significant or prolonged decline in the fair value of the security below its cost is considered to be objective evidence of impairment for shares classified as available-for-sale.

Individually significant financial assets are tested for impairment on an individual basis. The remaining financial assets are assessed collectively in groups that share similar credit risk characteristics.

All impairment losses are recognised in profit or loss. Any cumulative loss in respect of an available for sale financial asset recognised previously in equity is transferred to profit or loss.

Note 1 Statement of Significant Accounting Policies (continued)

(q) Impairment (continued)

Financial assets (continued)

An impairment loss is recognised if the carrying amount of an asset or its cash-generating unit exceeds its recoverable amount. A cash-generating unit is the smallest identifiable asset group that generates cash flows that largely are independent from other assets and groups.

Impairment losses are recognised in profit or loss. Impairment losses recognised in respect of cash-generating units are allocated first to reduce the carrying amount of any goodwill allocated to the units and then to reduce the carrying amount of the other assets in the unit (group of units) on a pro rata basis.

Impairment losses recognised in prior periods are assessed at each reporting date for indication that the loss has decreased or no longer exists. An impairment loss is reversed if there has been a change in the estimates used to determine the recoverable amount. An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss has been recognised.

(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) Grants

Grants are recognised initially as deferred income when there is reasonable assurance that they will be received and that the Group will comply with the conditions associated with the grant. Grants that compensate the Group for expenses incurred are recognised in profit or loss on a systematic basis in the same periods in which the expenses are recognised.

(t) Parent entity financial information

The financial information for the Parent Entity, as disclosed in Note 27 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.

Note 1 Statement of Significant Accounting Policies (continued)

(u) Assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use and a sale is considered highly probable. They are measured at the lower of their carrying amount and fair value less costs to sell, except for assets such as deferred tax assets, assets arising from employee benefits, financial assets and investment property that are carried at fair value and contractual rights under insurance contracts, which are specifically exempt from this requirement.

An impairment loss is recognised for any initial or subsequent write-down of the asset to fair value less costs to sell. A gain is recognised for any subsequent increases in fair value less costs to sell of an asset , but not in excess of any cumulative impairment loss previously recognised. A gain or loss not previously recognised by the date of the sale of the non-current asset is recognised at the date of derecognition.

Non-current assets (including those that are part of a disposal group) are not depreciated or amortised while they are classified as held for sale. Interest and other expenses attributable to the liabilities of a disposal group classified as held for sale continue to be recognised.

Assets classified as held for sale are presented separately from the other assets in the balance sheet.

(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 1 Statement of Significant Accounting Policies (continued)

(w) New standards and interpretations issued but not yet effective

Title	Key requirements	Effective date	Expected impact
AASB 9 Financial Instruments *AASB 2009-11 Amendments to Australian Accounting Standards arising from AASB 9* *AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010)* *AASB 2012-6 Amendments to Australian Accounting Standards – Mandatory Effective Date of AASB 9 and Transition Disclosures* *AASB 2013-9 Amendments to Australian Accounting Standards – Conceptual Framework, Materiality and Financial Instruments* *AASB 2014-1 Amendments to Australian Accounting Standard: Part E: Financial Instruments* *AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)* *AASB 2014-8 Amendments to Australian Accounting Standards arising from AASB 9 (December 2014) – Application of AASB 9 (December 2009) and AASB 9 (December 2010)*	AASB 9 replaces the multiple classification and measurement models in AASB 139 Financial instruments: Recognition and measurement with a single model that has initially only two classification categories: amortised cost and fair value. Classification of debt assets will be driven by the entity's business model for managing the financial assets and the contractual cash flow characteristics of the financial assets. A debt instrument is measured at amortised cost if: a) the objective of the business model is to hold the financial asset for the collection of the contractual cash flows, and b) the contractual cash flows under the instrument solely represent payments of principal and interest. All other debt and equity instruments, including investments in complex debt instruments and equity investments, must be recognised at fair value. All fair value movements on financial assets are taken through the statement of profit or loss, except for equity investments that are not held for trading, which may be recorded in the statement of profit or loss or in reserves (without subsequent recycling to profit or loss). For financial liabilities that are measured under the fair value option entities will need to recognise the part of the fair value change that is due to changes in the their own credit risk in other comprehensive income rather than profit or loss. In December 2015, the AASB made further changes to the classification and measurement rules and also introduced a new impairment model. With these amendments, AASB 9 is now complete.	1 January 2018	Not yet determined

Note 1 Statement of Significant Accounting Policies (continued)

(w) New standards and interpretations issued but not yet effective (continued)

Title	Key requirements	Effective date	Expected impact
AASB 15 Revenue from Contracts with Customers AASB 2014-5 Amendments to Australian Accounting Standards arising from AASB 15 AASB 2016-8 Amendments to Australian Accounting Standards – Effective Date of AASB 15 AASB 2016-3 Amendments to Australian Accounting Standards – Clarifications to AASB 15	The AASB has issued a new standard for the recognition of revenue. This will replace AASB 118 which covers contracts for goods and services and AASB 111 which covers construction contracts. The new standard is based on the principle that revenue is recognised when control of a good or service transfers to a customer – so the notion of control replaces the existing notion of risks and rewards.	1 January 2018	Not yet determined
AASB 16 Leases	AASB 16 will affect primarily the accounting by lessees and will result in the recognition of almost all leases on balance sheet. The standard removes the current distinction between operating and financing leases and requires recognition of an asset (the right to use the leased item) and a financial liability to pay rentals for virtually all lease contracts.	1 January 2019	Not yet determined

Note 2 Revenue and Expenses

	Note	Consolidated 2017 $'000	Consolidated 2016 $'000
Revenue			
Membership subscription		**12,343**	12,091
Database and data sales		**3,224**	3,434
Editorial		**603**	652
Commercial and member services		**2,778**	2,572
Doctors' Health Services		**1,587**	933
Rental		**628**	1,091
Interest		**347**	374
Unrealised gain on investment		**222**	–
Other income			
Dividend income	22	**–**	1
Other revenue including recoveries		**540**	440
		22,272	21,588
Expenses			
Contributions to employee superannuation plans		**921**	907
Cost of goods sold		**39**	33
Repairs and maintenance		**191**	286
Subsidies			
Subsidies to AMA States		**447**	397
Other subsidies		**39**	96
		486	493
Administration			
Finance costs		**–**	5
Loss on disposal of assets	22	**18**	2
Bad debt expense	22	**–**	5
Insurance		**163**	168
Travel and accommodation		**500**	408
Other		**2,056**	2,111
		2,737	2,699

Note 3 Auditor's Remuneration

Audit services		
Auditors of the Group		
RSM Australia Partners		
– Audit of financial report	**60**	58
Other services		
Auditors of the Group		
RSM Australia Pty Ltd		
– Taxation services	**16**	38
– Consulting services	**–**	7
	76	103

Note 4 Income tax (expense)/credit

	Consolidated	
	2017	2016
	$'000	$'000
Current tax (expense)/credit		
Prior year adjustments	**–**	(29)
	–	(29)
Deferred tax credit/(expense)		
Origination and reversal of temporary differences	**404**	458
Prior year adjustments	**(160)**	(3)
	244	455
Total income tax credit/(expense) in income statement	**244**	426
(Profit)/loss before income tax	**(17)**	1,014
Income tax using the domestic corporation tax rate of 27.5% (2016: 30%)	**(5)**	304
Increase in income tax expense due to:		
Mutual expenditure	**(3,681)**	(4,080)
Non-deductible expenses	**(7)**	(13)
Sundry	**(15)**	(47)
	(3,703)	(4,140)
Decrease in income tax expense due to:		
Mutual income	**4,031**	4,267
Fully franked dividends	**1**	17
Sundry	**80**	10
	4,112	4,294
Net change in income tax	**404**	458
Under provision for prior year – current tax expense	**–**	(29)
Under provision for prior year – deferred tax expense	**(160)**	(3)
	(160)	(32)
Income tax credit/(expense)	**244**	426
Attributable to:		
Continuing operations	**244**	426

Note 5 Cash and Cash Equivalents

	Note	Consolidated 2017 $'000	Consolidated 2016 $'000
Cash at bank		**2,359**	2,273
Short-term deposits		**1,254**	2,200
Cash on hand		**2**	2
Total Cash and cash equivalents	18	**3,615**	4,475

Classification of cash equivalents

Short-term deposits have a maturity of three months or less and earn interest at the respective short-term deposit rates.

Note 6 Trade and other receivables

Trade receivables		**653**	720
Provision for impairment		**(11)**	(13)
		642	707
Other receivables		**841**	789
Total Trade and other receivables	18	**1,483**	1,496

Movements in the provision for impairment of trade receivables that are assessed for impairment collectively are as follows:

Balance at 1 January	**(13)**	(11)
Receivables written off during the year as uncollectible	**–**	1
Unused amounts reversed	**2**	–
Provision for impairment recognised during the year	**–**	(3)
Balance at 31 December	**(11)**	(13)

(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's impairment and other accounting policies for trade and other receivables are outlined in notes 1(q) and 1(j) respectively.

(ii) Fair values of trade and other receivables

Due to the short-term nature of the current receivables, their carrying amount is considered to be the same as their fair value.

Note 6 Trade and other receivables (continued)

(iii) Impairment and risk exposure

Individual receivables which are known to be uncollectible are written off by reducing the carrying amount directly. The other receivables are assessed collectively to determine whether there is objective evidence that an impairment has been incurred but not yet been identified. For these receivables the estimated impairment losses are recognised in a separate provision for impairment.

The Group considers that there is evidence of impairment if any of the following indicators are present:

- significant financial difficulties of the debtor
- probability that the debtor will enter bankruptcy or financial reorganisation, and
- default or delinquency in payments (more than 30 days overdue).

Receivables for which an impairment provision was recognised are written off against the provision when there is no expectation of recovering additional cash.

Impairment losses are recognised in profit or loss within other expenses. Subsequent recoveries of amounts previously written off are credited against other expenses.

Based on the review of trade and other receivables at the reporting date, it is expected that these amounts will be received and not impaired.

Note 7 Inventories

	Consolidated	
	2017	2016
	$'000	$'000
Finished goods	**35**	38
Total Inventories	**35**	38

Note 8 Prepayments

	Consolidated	
	2017	2016
	$'000	$'000
Prepayments	**398**	436
Total Prepayments	**398**	436

Note 9 Other investments

	Consolidated	
	2017	2016
	$	$
Non-current assets		
Available for sale financial assets		
Managed securities fund	**4,540**	3,782
Shares in AMA Member Services Pty Ltd	**–**	–
Total Other investments	**4,540**	3,782

(a) Held-to-maturity investments

(i) Cash and term deposits

The fair value of cash and term deposits are $96,445 (2016: $404,611). Fair value was determined by reference to published price quotations in an active market.

(ii) Classification of financial assets as held-to-maturity

The AMA Group classifies investments as held-to-maturity if they are:

- Non-derivative financial assets;
- Quoted in an active market;
- Have fixed or determinable payments and fixed maturities; and
- The Group intends to, and is able to, hold them to maturity.

Held-to-maturity financial assets are included in non-current assets, except for those with maturities less than 12 months from the end of the reporting period, which would be classified as current assets.

(iii) Fair values of held-to-maturity

The fair values of the held-to-maturity investments are not materially different to their carrying amounts since the interest receivable is either close to current market rates or the instruments are short-term in nature.

(iv) Impairment and risk exposure

None of the held-to-maturity investments are either past due or impaired.

All held-to-maturity investments are denominated in Australian dollars. As a result, there is no exposure to foreign currency risk. There is also no exposure to price risk as the investments will be held to maturity.

Note 9 Other investments (continued)

(b) Available for sale financial assets

(i) Investments in related parties

Investment in AMA Member Services Pty Ltd was disposed in 2016 at nil value with a cost $1 and subsequently wound up in 2017.

(ii) Classification of financial assets as available for sale

Investments are designated as available for sale financial assets if they do not have fixed maturities and fixed or determinable payments, and management intends to hold them for the medium to long-term. Financial assets that are not classified into any other categories (at fair value through profit or loss, loans and receivables or held-to-maturity investments) are also included in the available for sale category.

The financial assets are presented as non-current assets unless they mature, or management intends to dispose them within 12 months of the end of the reporting period.

(iii) Impairment indicators for available for sale financial assets

A security is considered to be impaired if there has been a significant or prolonged decline in the fair value below its cost. See note 1(q) for further details about the impairment policies for financial assets.

None of the available for sale financial assets are either past due or impaired.

(iv) Fair value

The fair value of the equity securities is determined using the fair value of financial instruments traded in active markets (such as publicly traded derivatives, and trading and available for sale securities) based on quoted market prices at the end of the reporting period.

Note 10 Intangible assets

	Consolidated	
	2017	2016
	$'000	$'000
Membership database – at cost	**733**	733
Less: Accumulated amortisation	**(727)**	(726)
	6	7
Website – at cost	**56**	56
Less: Accumulated amortisation	**(56)**	(56)
	–	–
Computer software – at cost	**653**	283
Less: Accumulated amortisation	**(358)**	(190)
	295	93
IT Project developments – at cost	**218**	–
Less: Accumulated amortisation	**–**	–
	218	–
Total Intangible assets	**519**	100

Note 10 Intangible assets (continued)

Movement in carrying amounts:

Consolidated	Membership database	Website	Computer software	IT Projects	Total
	$'000	$'000	$'000	$'000	$'000
31 December 2016					
Opening written down value	4	10	45	41	100
Additions	–	–	37	–	37
Transfer	–	–	41	(41)	–
Reclassification	6	(6)	–	–	–
Amortisation	(3)	(4)	(30)	–	(37)
Closing written down value	7	–	93	–	100
31 December 2017					
Opening written down value	**7**	**–**	**93**	**–**	**100**
Additions	**–**	**–**	**253**	**218**	**471**
Amortisation	**(1)**	**–**	**(51)**	**–**	**(52)**
Closing written down value	**6**	**–**	**295**	**218**	**519**

Note 11 Investment properties

	Note	Consolidated 2017 $'000	Consolidated 2016 $'000
Units 1 and 2 Tourism House – at cost		**2,610**	2,610
Less: Accumulated depreciation		**(2,115)**	(2,010)
Total Investment properties		**495**	600

Movements in carrying amounts:

Consolidated		**Units 1 and 2 Tourism House $'000**	**Total $'000**
31 December 2016			
Opening written down value		711	711
Expensing of capitalised leased costs	22	(7)	(7)
Depreciation		(104)	(104)
Closing written down value		600	600
31 December 2017			
Opening written down value		**600**	**600**
Depreciation		**(105)**	**(105)**
Closing written down value		**495**	**495**

As at February 2015, Units 1 and 2 of Tourism House were valued at $3,640,000 ($4,935,000 at 13 January 2012). The valuation was prepared by Ms Sandra Howells AAPI, Certified Practising Valuer, of Egan National Valuers (ACT). As this value is in excess of the written down values disclosed above, no adjustment is necessary nor has been made within the financial statements.

Note 12 Property, plant and equipment

	Consolidated	
	2017	2016
	$'000	$'000
Leasehold land, AMA House – at cost	**–**	1,600
Buildings, AMA House – at cost	**–**	9,482
Add: Net capitalised lease expenditure	**230**	12
Less: Accumulated depreciation	**–**	(4,962)
	230	4,532
Property, Parap Rd, Parap – at cost	**381**	381
Less: Accumulated depreciation	**(62)**	(53)
	319	328
Office furniture – at cost	**1,521**	3,098
Less: Accumulated depreciation	**(1,185)**	(2,706)
	336	392
Office equipment – at cost	**202**	270
Less: Accumulated depreciation	**(120)**	(209)
	82	61
Fixtures and fittings – at cost	**293**	6,820
Less: Accumulated depreciation	**(49)**	(2,981)
	244	3,839
Computer hardware – at cost	**333**	466
Less: Accumulated depreciation	**(213)**	(320)
	120	146
Assets less than $300 – at cost	**67**	67
Less: Accumulated depreciation	**(67)**	(67)
	–	–
Personal computer network – at cost	**41**	123
Less: Accumulated depreciation	**(14)**	(87)
	27	36
Total Property, plant and equipment	**1,358**	10,934

Note 12 Property, plant and equipment (continued)

AMA House and the leasehold land have been classified as assets held for sale during the year, refer to Note 17 for further details.

An independent valuation of 2/25 Parap Road, Northern Territory was performed in February 2015 and valued at $420,000. Mr John Falvey, AAPI, Certified Practising Valuer, of Herron Todd White, 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.

Note 12 Property, plant and equipment (continued)

Movement in carrying amount: Consolidated	Opening written down value	Additions	Disposals	Depreciation	Capitalised lease costs	(Note 22) Capitalised lease costs expensed	Work in Progress	(Note 17) Transfer to Non-current Assets held for sale	Closing written down value
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
31 December 2016									
Leasehold land, AMA House	1,600	–	–	–	–	–	–	–	1,600
Buildings, AMA House	4,848	32	–	(237)	–	(111)	–	–	4,532
Property, Parap Rd Parap	337	–	–	(9)	–	–	–	–	328
Office furniture	242	225	–	(75)	–	–	–	–	392
Office equipment	87	8	(4)	(30)	–	–	–	–	61
Fixture and fittings	3,740	398	–	(299)	–	–	–	–	3,839
Computer hardware	99	109	–	(62)	–	–	–	–	146
Assets < $300	–	–	–	–	–	–	–	–	–
Personal computer network	4	37	–	(5)	–	–	–	–	36
	10,957	809	(4)	(717)	–	(111)	–	–	10,934
31 December 2017									
Leasehold land, AMA House	**1,600**	**–**	**–**	**–**	**–**	**–**	**–**	**(1,600)**	**–**
Buildings, AMA House	**4,532**	**–**	**–**	**(198)**	**248**	**(30)**	**–**	**(4,322)**	**230**
Property, Parap Rd Parap	**328**	**–**	**–**	**(9)**	**–**	**–**	**–**	**–**	**319**
Office furniture	**392**	**18**	**(9)**	**(65)**	**–**	**–**	**–**	**–**	**336**
Office equipment	**61**	**54**	**(8)**	**(25)**	**–**	**–**	**–**	**–**	**82**
Fixture and fittings	**3,839**	**338**	**–**	**(275)**	**–**	**–**	**–**	**(3,658)**	**244**
Computer hardware	**146**	**48**	**(3)**	**(71)**	**–**	**–**	**–**	**–**	**120**
Assets < $300	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Personal computer network	**36**	**–**	**(2)**	**(7)**	**–**	**–**	**–**	**–**	**27**
	10,934	**458**	**(22)**	**(650)**	**248**	**(30)**	**–**	**(9,580)**	**1,358**

Note 13 Deferred tax assets and liabilities

Consolidated	Deferred Tax Assets		Deferred Tax Liabilities		Total	
	2017	2016	2017	2016	2017	2016
	$'000	$'000	$'000	$'000	$'000	$'000
Property, plant and equipment	**386**	431	**–**	–	**386**	431
Accruals	**45**	124	**–**	–	**45**	124
Employee benefits	**123**	134	**–**	–	**123**	134
Other	**(59)**	(19)	**–**	–	**(59)**	(19)
Carried forward losses	**765**	346	**–**	–	**765**	346
Total Deferred tax assets/(liabilities)	**1,260**	1,016	**–**	–	**1,260**	1,016

Movement in temporary differences:

Consolidated	Property, plant and equipment	Accruals	Employee benefits	Other	Carried forward losses	Total
	$'000	$'000	$'000	$'000	$'000	$'000
31 December 2016						
Opening written down value	172	91	121	3	174	561
Recognised in income statement	259	33	13	(22)	172	455
Closing written down value	431	124	134	(19)	346	1,016
31 December 2017						
Opening written down value	**431**	**124**	**134**	**(19)**	**346**	**1,016**
Recognised in income statement	**(45)**	**(79)**	**(11)**	**(40)**	**419**	**244**
Closing written down value	**386**	**45**	**123**	**(59)**	**765**	**1,260**

Note 14 Trade and other payables

	Note	Consolidated 2017 $'000	Consolidated 2016 $'000
Trade payables		**403**	480
Other payables and accruals		**1,131**	1,063
Income in advance		**949**	891
Total Trade and other payables	18	**2,483**	2,434

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

The carrying amounts of trade and other payables are considered to be the same as their fair values, due to their short-term nature.

Note 15 Employee benefits

	Consolidated 2017 $'000	Consolidated 2016 $'000
Current		
Long service leave provision	**513**	481
Annual leave provision	**707**	684
	1,220	1,165
Non-current		
Long service leave provision	**133**	117
Total Employee benefits	**1,353**	1,282

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 receivable

	Consolidated 2017 $'000	Consolidated 2016 $'000
Income tax receivable	**–**	173
Total Income tax receivable	**–**	173

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 Assets held for sale

	Consolidated	
	2017	2016
	$'000	$'000
Assets held for sale		
Land	**1,600**	–
Buildings, AMA House	**4,322**	–
Fittings	**3,658**	–
Capitalised selling costs	**148**	–
Total assets held for sale	**9,728**	–

(a) Description

AMA House was made available for sale during the year and the sale contract exchanged, with settlement occurring in March 2018. On settlement, the Group entered into a 5-year tenancy lease agreement with the building owner to occupy the 4th floor of AMA House, retaining naming rights to the building. Refer to Note 25 Subsequent events for further information.

Note 18 Financial Instruments and Risk Management

Risk management

The Board of Directors, through its Audit and Risk Committee, manages the financial risks relating to the operations of the Group. The Group adopts prudent risk based management procedures. The Audit and Risk Committee oversees how the Group complies with the Group's risk management procedures. 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	
		2017	2016
	Note	**$'000**	$'000
Financial assets			
Cash and cash equivalents	5	**3,615**	4,475
Trade and other receivables	6	**1,483**	1,496
Available for sale financial assets	9	**4,540**	3,782
		9,638	9,753

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.

Past due but not impaired

As at the reporting date, trade receivables of $443,000 (2016: $501,000) were past due but not impaired. These relate to a number of independent customers for whom there is no recent history of default. The ageing analysis of these trade receivables is as follows:

	Consolidated	
	2017	2016
	$'000	$'000
Not due and not impaired	**1,040**	995
Past due and not impaired		
Up to 3 months	**348**	338
3 to 6 months	**95**	150
Over 6 months	**–**	13
	443	501
Total Trade and other receivables	**1,483**	1,496

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 18 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 the return.

(i) Interest risk

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

		Consolidated	
		2017	2016
	Note	**$'000**	$'000
Fixed rate instruments			
Held to maturity investments			
Short term deposits	5	**1,254**	2,200
		1,254	2,200
Variable rate instruments			
Financial assets			
Cash at bank	5	**2,359**	2,273
		2,359	2,273

Fair value sensitivity analysis for fixed rate instruments

The Group does not account for any fixed rate financial assets and liabilities at fair value through profit or loss. Therefore a change in interest rates at the reporting date would not affect profit or loss.

Cash flow sensitivity analysis for variable rate instruments

Profit or loss is sensitive to higher or lower interest income from cash and cash equivalents as a result of changes in interest rates. The impact of 100 basis points in interest rates would have increased or decreased the Group's profit or loss by $36,000 (2016: $45,000). This analysis assumes that all other variables remain constant.

(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.

(iii) Equity risk

The Group's exposure to equity risk is immaterial as the Group does not have significant investments in equity which can fluctuate in price.

Note 18 Financial Instruments and Risk Management (continued)

(b) Market risk (continued)

(iv) Price risk

		Consolidated	
		2017	2016
Financial assets	**Note**	**$'000**	$'000
Non-current assets			
Available for sale financial assets			
Managed fund – Australian securities		**2,796**	2,474
Managed fund – International securities		**1,744**	1,308
	9	**4,540**	3,782

Exposure

The Group's exposure to equity securities price risk arises from investments held by the Group and classified in the balance sheet either as available for sale or at fair value through profit or loss.

To manage its price risk arising from the available for sale investments, the Group diversified its portfolio through a managed fund. Diversification of the portfolio is done through its Investment Committee and endorsed by the Board.

Sensitivity

The impact of a 1% change in price, arising from the Group's available for sale financial assets, would have increased or decreased the Group's profit or loss by $45,000 (2016: $38,000). This analysis assumes that all other variables remain constant.

Note 18 Financial Instruments and Risk Management (continued)

(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.

The following are the contractual maturities of financial liabilities; including estimated interest payments and excluding the impact of netting agreements:

Consolidated Non-derivative financial liabilities	Note	Carrying amount $'000	Contractual cash flows $'000	6 months or less $'000	6 – 12 months $'000	1 – 2 years $'000	2 – 5 years $'000	More than 5 years $'000
31 December 2016								
Trade and other payables	14	2,434	(2,434)	(2,434)	–	–	–	–
		2,434	(2,434)	(2,434)	–	–	–	–
31 December 2017								
Trade and other payables	14	**2,483**	**(2,483)**	**(2,483)**	**–**	**–**	**–**	**–**
		2,483	**(2,483)**	**(2,483)**	**–**	**–**	**–**	**–**

(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 19 Operating leases

Leases as lessee:

Non-cancellable operating lease rentals are payable as follows:

	Consolidated	
	2017	2016
	$'000	$'000
Not later than 1 year	**11**	11
Later than 1 year but not later than 5 years	**10**	21
	21	32

Leases as lessor:

The Group leases out its investment property under operating leases (see Note 11).

The future minimum rent receivable under non-cancellable leases are as follows:

Investment property

Not later than 1 year	**22**	12
Later than 1 year but not later than 5 years	**–**	–
	22	12

Other property

Not later than 1 year	**–**	406
Later than 1 year but not later than 5 years	**–**	1,362
	–	1,768

Total

Not later than 1 year	**22**	418
Later than 1 year but not later than 5 years	**–**	1,362
	22	1,780

The Group has entered into commercial property leases for its properties. Tourism House is classified as an investment property because no member of the Group occupies any floor area of that property. Commercial leasing of carparks continue into the foreseeable future.

Lease payments escalate each year by CPI. The future minimum rent receivable has been calculated on the assumption that CPI will average 2.0% each year. The lease does not contain any contingent rentals.

AMA House was classified as other property. It was not classified as an investment company because the parent entity occupies the 4th floor. Several leases, for different terms, exist over tenancies within AMA House. Where there is no certainty that a lease commitment exists or will exist at a point in the future, no rent receivable has been disclosed. Some leases have fixed percentage annual escalations and some escalations are linked to CPI. As at 31 December 2017, AMA House is classified as asset held for sale, refer to Note 17 Assets held for sale and Note 25 Subsequent events for further information.

Note 19 Operating leases (continued)

During the year ended 31 December 2017, $628,000 was recognised as rental income in the Statement of Comprehensive Income (2016: $1,091,000). Direct operating expenses recognised in the Statement of Comprehensive Income relating to property was $1,246,000 (2016: $1,371,000).

Note 20 Commitments

	Consolidated	
	2017	2016
	$'000	$'000
Expenditure commitment:		
Not later than 1 year	**437**	480
Later than 1 year but not later than 5 years	**847**	1,313
	1,284	1,793
Commitments receivable		
Not later than 1 year	**24**	46
Later than 1 year but not later than 5 years	**–**	23
	24	69

Note 21 Controlled entities

	Consolidated	
	2017	2016
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
Actraint No. 110 Pty Limited	**2**	2
Doctors' Health Services Pty Ltd	**1**	1
AMA Commercial Pty Ltd	**–**	2
	7	9

The controlled entities, Australasian Medical Publishing Company Proprietary Limited, AMA Pty Limited, AMA Commercial Pty Ltd, AMA NT Pty Ltd, Actraint No. 110 Pty Limited and Doctors Health Services Pty Ltd, are incorporated in Australia and are 100% controlled by the Australian Medical Association Limited.

AMA Commercial Pty Ltd has ceased operations in 2016 and has wound up in 2017.

AMA Pty Limited acts as trustee for the AMA Property Trust. Actraint No. 110 Pty Limited acts as trustee for the AMA Investment Trust.

The Australian Medical Association Limited owns 100% of units in the AMA Investment Trust. The AMA Investment Trust owns 100% of units in the AMA Property Trust.

Note 22 Reconciliation of Cash Flows from Operating Activities

	Note	Consolidated 2017 $'000	Consolidated 2016 $'000
Profit/(loss) for the year		**261**	(588)
Less: Items classified as investing activities			
Dividends received	2	**–**	(1)
Add: Non-cash items			
Depreciation and amortisation		**807**	858
Loss on disposal of assets		**18**	2
Bad debt expense		**–**	5
Expensed of capitalised leased costs	11, 12	**30**	118
Net movement in provision for employee entitlements		**71**	79
		1,187	473
Changes in operating assets and liabilities:			
Decrease – Trade and other receivables		**51**	553
Decrease/(increase) – Inventories		**3**	(4)
(Decrease) – Trade and other payables		**(570)**	(1,003)
(Increase)/decrease – Provision for tax liabilities		**(71)**	296
Net cash flow from operating activities		**600**	315

Note 23 Directors and Executive disclosure

Transactions with Directors and Key Management Personnel

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 2017 $'000	Consolidated 2016 $'000
Short-term employee benefits	**3,034**	2,692
Termination benefits	**–**	374
	3,034	3,066

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 24 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	
	2017	2016
	$	**$**
The Mervyn Archdall Medical Monograph Fund	**–**	19,273
The Federal Medical War Relief Fund	**–**	5,546
The Federal Independence Fund	**–**	3,210
The Indigenous Peoples' Medical Scholarship Trust Fund	**119,864**	148,933
The AMA Indigenous Medical Scholarship Foundation	**71,701**	10
	191,565	176,972

The historical funds have been wound up during the financial year. The expenses of winding up the Federal Medical War Relief Fund and the Federal Independence Fund have exhausted what remains in these funds. The Mervyn Archdall Medical Monograph Fund had a remaining $17,830, which has been contributed to its subsidiary, Doctors Health Services Pty Ltd, in June 2017, to be used for the purpose of looking after the health of doctors.

AMA Pty Limited acts as trustee for the Indigenous Peoples' Medical Scholarship Trust Fund (the 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 25 Subsequent events

The sale of AMA House settled on 28 March 2018. When the property transaction settled, the taxing point under the capital gains tax provisions was taken to be at the date the contracts were exchanged. However, as a number of conditions precedent to settlement had not eventuated as at the balance sheet date, no taxable capital gain has been recorded.

The Group entered into a 5 year rental lease for the 4th floor of AMA House, retaining naming rights to the building and novating all commercial leases for the building over to the purchaser. The value of commitments for this rental lease is approximately $2.47m.

Other than the sale of AMA House, no 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 26 Company details

The Group comprises the parent entity, Australian Medical Association Limited and its controlled entities, being:

- Australasian Medical Publishing Company Proprietary Limited
- AMA Pty Limited
- AMA NT Pty Ltd
- Actraint No.110 Pty Limited
- Doctors Health Services Pty Ltd
- AMA Commercial Pty Ltd

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

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

AMA Pty Limited is a company limited by shares, incorporated and domiciled in Australia. The registered office of this company is 4th Floor, 42 Macquarie Street, Barton ACT 2600. This company acts as trustee for the AMA Property Trust. The Trust owns, manages and rents commercial properties in Barton, ACT.

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

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

Doctors Health Services Pty Ltd is a company limited by shares, incorporated and domiciled in Australia. The registered office of this company is 4th floor, 42 Macquarie Street, Barton, ACT 2600. This company manages the delivery of a health service for medical practitioners and medical students.

AMA Commercial Pty Ltd is a company limited by shares, incorporated and domiciled in Australia. The registered office of this company is 4th Floor, 42 Macquarie Street, Barton ACT 2600. This company manages the commercial member benefits program and associated commercial contracts. This company was wound up during the financial year, with its business operation and commercial contracts transferred to AMA Limited.

Note 27 Parent entity

As at, and throughout the financial year ended 31 December 2017, 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.

(a) Financial information

	2017 $'000	2016 $'000
Profit/(loss) for the year	**303**	(901)
Total comprehensive profit/(loss)	**303**	(901)

The profit/(loss) for the year includes a dividend of nil (2016: $234,000 from AMA Commercial Pty Ltd).

Statement of financial position		
Assets		
Current assets	**4,641**	6,505
Non-current assets	**15,412**	10,596
Total assets	**20,053**	17,101
Liabilities		
Current liabilities	**1,579**	1,611
Non-current liabilities	**3,024**	343
Total liabilities	**4,603**	1,954
Equity		
Retained earnings	**15,450**	15,147
Total equity	**15,450**	15,147

(b) Guarantees

A guarantee provided by the Australian Medical Association Limited in favour of The Council of the City of Sydney exists for the rent of Australasian Medical Publishing Company Pty Ltd premises at Town Hall House.

(c) Other commitments

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

(d) Contingent liabilities

There are no contingent liabilities at the reporting date.

Note 28 Related party transactions

Parent entities

The wholly owned group consists of Australian Medical Association Limited and its controlled entities. These entities are Australasian Medical Publishing Company Proprietary Limited, AMA Pty Limited, AMA Commercial Pty Ltd, AMA NT Pty Limited, Actraint No 110 Pty Limited, AMA Property Trust and Doctors Health Services Pty Limited. AMA Commercial Pty Ltd has wound up during the financial year.

Parent entity

The parent entity of the wholly owned group is Australian Medical Association Limited.

Ownership interest in related parties

Interests held in related parties are as follows:

Name of entity	Class of shares	Equity holding 2017 %	Equity holding 2016 %
Australasian Medical Publishing Company Proprietary Limited	Ordinary	**100**	100
AMA Pty Limited	Ordinary	**100**	100
AMA NT Pty Ltd	Ordinary	**100**	100
Actraint No 110 Pty Ltd	Ordinary	**100**	100
Doctors Health Services Pty Ltd	Ordinary	**100**	100
AMA Commercial Pty Ltd	Ordinary	**–**	100

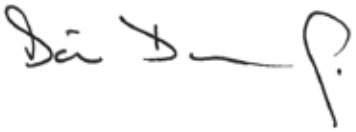
Directors' Declaration

The Directors of the Company declare that:

1) the financial statements and notes, set out on pages 66 to 113 are in accordance with the Corporations Act 2001, and
   i) comply with Australian accounting standards; and
   ii) gives a true and fair view of the financial position as at 31 December 2017 and of the performance for the year ended on that date, of the Company and consolidated Group.
2) In the Directors' opinion there are reasonable grounds to believe that the Company will be able to pay its debts as and when they become due and payable.

This declaration is made in accordance with a resolution of Directors dated this 17th day of April 2018.

Dr Michael Gannon
Director
Australian Medical Association Limited



Dr Iain Dunlop
Director
Australian Medical Association Limited

Auditors' Independence Declaration

RSM Australia Partners

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AUDITOR'S INDEPENDENCE DECLARATION

As lead auditor for the audit of the financial report of Australian Medical Association Limited and its Controlled Entities for the year ended 31 December 2017, I declare that, to the best of my knowledge and belief, there have been no contraventions of:

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

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

RSM AUSTRALIA PARTNERS

GED STENHOUSE
Partner

Canberra, Australian Capital Territory
Dated: 23 April 2018

Independent Audit Report

RSM Australia Partners

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INDEPENDENT AUDITOR'S REPORT

TO THE MEMBERS OF

AUSTRALIAN MEDICAL ASSOCIATION LIMITED

Opinion

We have audited the financial report of Australian Medical Association Limited (the Company) and its subsidiaries (the Group), which comprises the consolidated statement of financial position as at 31 December 2017, the consolidated statement of comprehensive income, the consolidated statement of changes in equity and the consolidated statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies, and the directors' declaration.

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

(i) giving a true and fair view of the Group's financial position as at 31 December 2017 and of its financial performance for the year then ended; and

(ii) complying with Australian Accounting Standards and the Corporations Regulations 2001.

Basis for Opinion

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

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

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

Other Information
The directors are responsible for the other information. The other information comprises the information included in the Group's annual report for the year ended 31 December 2017, but does not include the financial report and the 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.

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

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

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

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

RSM

RSM AUSTRALIA PARTNERS

GED STENHOUSE
Partner

Canberra, Australian Capital Territory
Dated: 23 April 2018

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