Australian Medical Association

Annual Report 2018

AMA

Editor
John Flannery, Federal AMA

Sub Editors
Maria Hawthorne, Federal AMA
Odette Visser, Federal AMA

Graphic Design
CRE8IVE

Typesetting
Keep Creative

Contents

Australian Medical Association Limited

Strategic Plan 2018–2020

Mission

Leading Australia's Doctors – Promoting Australia's Health

Strategic Objectives

- **Leading on Advocacy**
- **Recognising and Valuing Our Members**
- **Strengthening Our AMA Community**
- **Ensuring Financial Security**

Our AMA – Working for Diversity and Inclusion

2018 AMA Federal Council

Above: AMA Federal Councillors attend their August meeting in Canberra

Dr Tony Bartone
Dr Michael Gannon
Dr Chris Zappala
A/Prof Beverley Rowbotham
Dr Antonio Di Dio
Dr Kean-Seng Lim
A/Prof Rob Parker
Dr Dilip Dhupelia
A/Prof William Tam
Dr John Davis
Dr Will Blake
Dr Mark Duncan-Smith
A/Prof Saxon Smith
Dr Shaun Rudd
Dr Chris Moy
Dr Helen McArdle
Dr Jill Tomlinson
Dr Janice Bell
Dr Andrew J Miller
Dr Andrew C Miller
A/Prof David Mountain
Dr Richard Kidd
Prof Steve Robson
Dr Brad Horsburgh
Dr Omar Khorshid
Dr Paul Bauert
Dr Matt McConnell
Prof Steve Kisely
Prof Mark Khangure
Dr Owen Ung
Dr Tessa Kennedy
Dr Sandra Hirowatari
A/Prof Julian Rait
Dr Roderick McRae
Ms Alex Farrell
Dr Kali Hayward
Dr Kris Rallah-Baker

1.

President's Report

It has been another outstanding year of advocacy by the AMA on behalf of members, the broader medical profession, and the community.

The Federal AMA has a hard-earned and well-deserved reputation as one of the most successful and high-profile lobby groups in the country.

We are regularly quoted in Parliament, from the Prime Minister down.

We are always in the media, and our health policy and messages are popular with the Australian public.

We work collaboratively with the medical Colleges, Societies, and Associations, and with other health groups.

People look to us for leadership on health advocacy – across the broad medical and health landscape. They seek us out for our views consistently.

We provide high quality work and results for our members. We provide great value for our members.

This reputation does not come easily. It takes hard work and dedication. It takes good ideas, research, analysis, strategy, and experience.

The depth and breadth of our policy is unmatched among professional associations in this country. Our positions are based on evidence that comes from our grassroots members in surgeries, hospitals, and other health settings around the country.

Dr Tony Bartone
President

Our policies reflect the realities of everyday medical and health interactions. Our policies represent the needs of doctors and their patients. Our policies have the ultimate evidence base – the health system at work in every part of Australia.

Our leadership on policy and advocacy was on display to great effect in 2018.

Looking at our year in review, the Government has been preoccupied with ongoing reviews of its own in health – the MBS review, the review of Private Health Insurance, and the Aged Care Royal Commission being the biggest headliners.

Looking back over our year of activity – via media comment, submissions, Senate and Parliamentary hearings, meetings with MPs and Senators, correspondence, and feedback from members – the themes have been consistent and strong: fund general practice; fix aged care; fix private health; fund public hospitals; do more in mental health; lobby on public health issues like obesity, smoking, vaccination and sugar; do something about the health of asylum seekers; and advocate for the issues confronting our doctors and patients in rural and regional Australia.

Our leadership on policy and advocacy was on display to great effect in 2018.

These issues were front and centre month after month, day after day – throughout the year.

But they weren't the only things to take our time and effort.

We did a lot of work on issues that concern all doctors – mandatory reporting, medical indemnity, euthanasia, Doctors' Health Services, and the Code of Conduct for Doctors stand out.

Then there were the broader social, political, environmental, and community issues that have an impact on people's health – climate change, the Uluru Statement from the Heart, and the AMA's very own Anti-Racism Statement.


SURGERY

The effectiveness of our advocacy – and ability to influence policy – was on show right from the early weeks of the year, first with the release of our Budget Submission and our Public Hospital Report Card, then our Private Health Insurance Report Card.

Our work on the MBS Review and private health was demanding, ongoing, and significant. It is all unfinished business of significant imperative, clearly looming as a real "existential" threat … a line in the sand for the profession.

As you read through this report, you will notice that our work has directly or indirectly touched on many aspects of the lives of everyday Australians. I am proud of that work. All AMA members should be proud of that work.

The AMA is in very good shape to achieve substantial policy outcomes for our members and the profession at the 2019 election. We are in a key position to influence the health policies of the major parties for the benefit of our patients.

I would like to thank my predecessor, Dr Michael Gannon, for his leadership, inspiration, and friendship. I thank my Vice President, Dr Chris Zappala, for his support, his counsel, his dedication to the profession and our patients, and his commitment to make the AMA an even better organisation.

My thanks also to the Federal Council and its Committees, the AMA Board, the many and extremely talented unsung heroes that are the AMA Secretariat, the State and Territory AMAs, and all our members for contributing to our success.

Above all, thanks to my partner and my family for backing me in this important job and being there for me in those rare times when I can switch off the 'AMA Open' light.

Dr Tony Bartone
President

2.

Chair of Board Report

The AMA Board's work is focused on the governance, finances, and risk management of the company and its subsidiary companies, with AMA Federal Council and its councils and committees being the driver of policy development and advocacy.

Having joined the AMA Board in June, I was proud to be elected as Chair of the Board on 29 November 2018 following the resignation of Dr Iain Dunlop as Chair.

As Chair, Dr Dunlop made a very significant contribution to the work of the Board over a three and a half year period. We are fortunate that, even though he has stepped down as Chair, he continued in his role as a director.

2018 also saw Dr Elizabeth Feeney and Professor Geoff Dobb complete their terms as Board members, being replaced by Dr Danielle McMullen and Professor Rosanna Capolingua.

I would like to extent my appreciation to the retired directors as well as all my fellow directors for their dedication and commitment to the Association.

Our 2018–2020 strategic plan came into effect on 1 January 2018. The plan focuses on advocacy, recognising and valuing our members, a collaborative relationship with State and Territory AMAs and ensuring the financial security of the Association. For the first time, it also recognised the importance of diversity and inclusion.

The financial results for the year are solid, although future forecasts highlight that the Board will need to remain vigilant in reviewing expenditure.

Associate Professor Gino Pecoraro
Chair

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

The Investment Committee worked hard in providing advice to the Board to ensure that the proceeds of the sale of AMA House are invested wisely and provide the Association with a reliable long-term revenue stream. With the sale of our units in Tourism House, we hope to bolster this revenue stream further.

Similarly, the Audit and Risk Committee worked with the Board to finalise a Group Risk Appetite Statement and Group Risk Management Plan.

One of the most significant responsibilities of a Board is the recruitment of a Secretary General. While the Board had in place a clear plan to ensure a smooth transition following the departure of Ms Anne Trimmer in August, the resignation of Dr Michael Schaper in October led to the implementation of interim arrangements including the appointment of Mr Warwick Hough as Acting Secretary General.

The Board is very grateful to the staff in the federal secretariat for the way in which they have stepped up to ensure the continued effective functioning of the organisation. Members can also be reassured that we have reflected on the recruitment process and will take a measured approach as we look to fill this critical role in the organisation.

I would like to particularly thank the senior staff who have worked closely with the Board during the year as well as all members of our Secretariat who have contributed to our organisation's strength and success in its many and various activities.

Associate Professor Gino Pecoraro
Chair

3.

AMA Board Members

From left to right: Dr Bavahuna Manoharan, Dr Gary Speck, A/Prof Rosanna Capolingua, Dr Peter Sharley, Dr Tony Bartone, Dr Danielle McMullen, Dr Christopher Zappala, A/Prof Gino Pecoraro, Dr Helen McArdle, Dr Iain Dunlop. Absent: Dr Danika Thiemt.

A/Professor Gino Pecoraro

MBBS, FRANZCOG, FAMA

Chair
Obstetrician & Gynaecologist
(Board Member from June 2018)

A/Professor Rosanna Capolingua

MBBS, FAMA, FAICD

Deputy Chair
General Practitioner
(Board Member from May 2018)

Dr Anthony Bartone

MBBS, FRACGP, MBA, FAMA

President, AMA
General Practitioner

Dr Christopher Zappala

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

Vice President, AMA
Thoracic and Sleep Physician

Dr Bavahuna Manoharan

BSc (BioMed), MBBS, GAICD

Audit and Risk Committee member
Medical Administration 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

Dr Danielle McMullen

MBBS (Hons), FRACGP, DCH, GAICD

General Practitioner

Prof Geoffrey Dobb

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

Investment Committee member
Intensive Care Physician
(Board Member to May 2018)

Dr Iain Dunlop AM

MBBS (Hons), FRANZCO, FRACS, FAMA

Ophthalmologist
(Board Chair to November 2018)

Dr Elizabeth Feeney

MBBS, MHL, FANZCA, FAICD, FAMA

Investment Committee member
Anaesthetist
(Board Member to May 2018)

Dr Michael Gannon

MBBS, MRCPI, FRANZCOG, FAMA

Obstetrician and Gynaecologist
(Board Member to May 2018)

4.

Advocacy

Above left: Dr Gannon meets with Shadow Health Minister Catherine King
Above right: Dr Gannon meets with Minister for Regional Services, Senator Bridget McKenzie
Right: Dr Gannon meets with Health Minister Greg Hunt

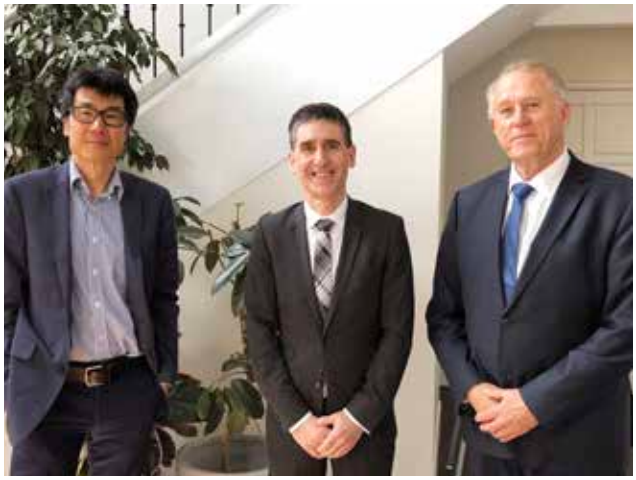
Top: Dr Gannon with Shadow Assistant Minister for Indigenous Health Warren Snowdon in the NT
Above left: Dr Bartone meets Shadow Finance Minister Jim Chalmers
Above right: Dr Gannon and Dr Brendan Nelson at the Australian War Memorial in Canberra
Right: Television cameras line up to record the AMA response to the 2018–19 Federal Budget

Dr Gannon meets Finance Minister Mathias Cormann and then Treasurer Scott Morrison before responding to questions from the media on the 2018–19 Budget

Top left: Dr Bartone meeting with Shadow Health Minister Catherine King
Middle left: Dr Bartone meeting Health Minister Greg Hunt
Bottom left: Dr Gannon meeting Minister for Indigenous Health Ken Wyatt
Below: Dr Gannon meeting Senator Kristina Keneally

Top: Dr Bartone addresses the media
Left: Dr Bartone meets with the President of the Royal Australian College of General Practitioners, Dr Harry Nespolon, and Prof Bruce Robinson, chair of the MBS Review Taskforce

Top left: Dr Bartone and Health Minister Greg Hunt meet to discuss My Health Record
Top right: Dr Bartone meets with Opposition Leader Bill Shorten
Below: Dr Bartone appears on Sky News to discuss supervised pill testing trials



Top: Dr Bartone and representatives from the National Aboriginal Community Controlled Health Organisation discuss Indigenous health with the Minister, Ken Wyatt

Left: Dr Bartone with Minister for Regional Services, Senator Bridget McKenzie

Below left: Dr Bartone meets Prof Kingsley Faulkner and Dr Richard Yin from Doctors for the Environment

5.

2018 AMA Media Reach Analytics

Facebook

Australian Medical Association

124
Facebook posts

15,856
Total fans

1,137,443
Impressions

Twitter

@ama_media

20,089 Followers

1,535 Tweets

6,926,475 Impressions

@amaausmed

4,726 Followers

145 Tweets

221,937 Impressions

@amapresident

17,349 Followers

474 Tweets

2,012,791 Impressions

206 **Media releases, speeches, and transcripts** were distributed by the AMA in 2018

6.

Year in Review

Top: Dr Bartone and Dr Gannon launch the AMA Public Hospital Report Card in Brisbane

Left: A/Prof Susan Neuhaus delivers the ANZAC Day address at the Dawn Service at the Australian War Memorial, Canberra

Above: Dr Bartone, A/Prof Julian Rait, and Medical Practice Policy Director, Luke Toy, address the Private Health Insurance Senate Committee
Right: Dr Gannon attends the World Medical Association meeting in Riga, Latvia

Top: Dr Bartone celebrates 2018 Family Doctor Week

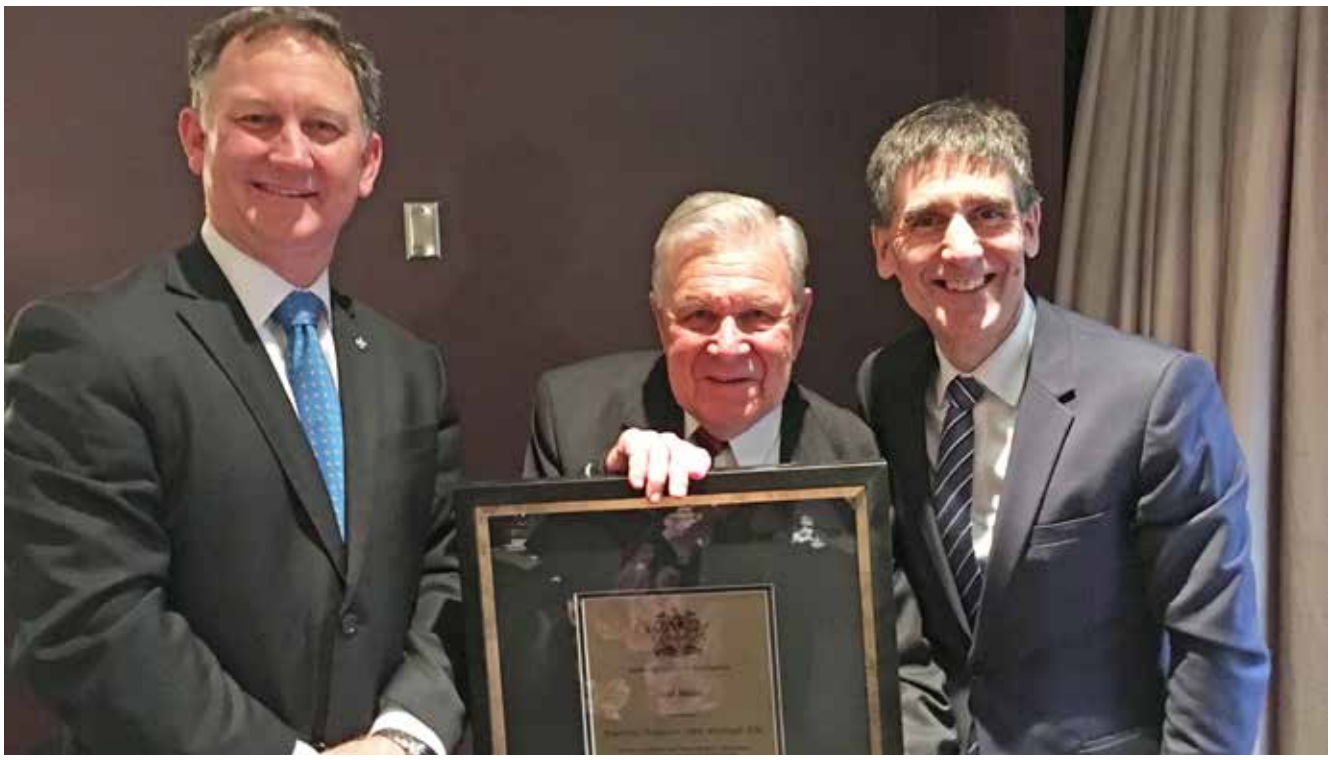
Left: Dr Bartone and Health Minister Greg Hunt meet at the Women's Health Forum

Above: Dr Bartone delivers the National Press Club Address

Right: Dr Bartone meets with Australian National Rural Health Commissioner, Prof Paul Worley
Below left: Dr Bartone attends the Confederation of Medical Associations in Asia and Oceania with Dr Mohamed Namazie Ibrahmin and Dr Ravindran Naidu
Below right: AMA Future Leaders visit Parliament House
Bottom: Dr Kean-Seng Lim, Dr Chris Moy, and AMA Policy Director Luke Toy address the Senate Community Affairs Committee on My Health Record

Top: Dr Bartone attends the Australian Indigenous Doctors' Association Conference

Bottom: Dr Bartone on ABC24



Top: Dr Gannon and Dr Bartone award the 2018 AMA Gold Medal to Emeritus Professor John Murtagh

Bottom left: Dr Bartone visits the Yulu-Burri Ba clinic at Capalaba in Brisbane

Bottom right: Dr Bartone, National Rural Health Commissioner, Prof Paul Worley, and A/Prof Beverley Rowbotham

Dr Bartone released the AMA Indigenous Health Report Card 2018 in Brisbane in November. He was joined by Deadly Choices Ambassadors, Australian record holder sprinter Patrick Johnson, champion bodybuilder Rhonda Purcell, and elite women's rugby league player Tallisha Harden. Shadow Assistant Health Minister for Indigenous Health, Warren Snowdon, also spoke at the event.

Top: Dr Gannon with members of the Pintupi Homelands Health Service Aboriginal Corporation board in Kintore, Northern Territory

Left: Dr Gannon presents the AMA President's Award to rural GP, Dr David Rivett.

Below left: Dr Bartone attends the Rural Generalist Pathways meeting

7.

General Practice, Legal Services, and Workplace Policy

During 2018, the AMA General Practice and Workplace Policy Section revised or developed the following Position Statements/policy documents:

- *General Practice/hospitals transfer of care arrangements 2018*
- *Non-Vocationally Registered General Practitioners 2013* (rescinded following review)
- 2018 AMA National Conference policy papers on:
  - Ending discrimination in recruitment, employment and flexible work practices
  - The importance of broad experience in a variety of clinical fields for selection into vocational training versus clinical research prerequisites
  - Additional funding for quarantined training places as part of the National Rural Generalist Pathway

Reports/Surveys

- Medical Workforce and Training Summit and Report, 3 March 2018
- Australian and New Zealand Prevocational Medical Education Forum, 11–14 November 2018:
  - Putting doctors in the bush: changes to the bonded medical place program
  - Social media, ethics and medical professionalism: a revised guide
  - Is prevocational research worth the (CV) paper it's written on?

Submissions

- Senate Standing Committee on Economics Inquiry into the indicators of, and the impact of, regional inequality in Australia
- Rural Procedural Training Programs Review and Reform Options
- Principles of the More Doctors for Rural Australia Program
- National Rural Generalist Taskforce Advice to the National Rural Health Commissioner on the Development of the National Rural Generalist Pathway
- National Strategic Action Plan for Arthritis
- Australian Institute of Health and Welfare (AIHW) consultation paper *A potentially preventable hospitalisation indicator specific to general practice*
- RACGP Standards for the Point of Care Testing (POCT)
- Australian Commission on Safety and Quality in Healthcare (ACSQHC) discussion paper on Patient safety and quality improvement in primary care
- RACGP Standards for After Hours services
- Australian Medical Council (AMC) review of accreditation of the education and training program provided by the:
  - College of Intensive Care Medicine (CICM) June 2018
  - Australasian College of Sport and Exercise Physicians (ACSEP) July 2018
  - Australian and New Zealand College of Anaesthetists (ANZCA) September 2018
- The Senate Select Committee on the Future of Work and Workers
- RACP Review – *Implementation of computer-based divisional written exam in adult medicine and paediatric and child health*
- Fair Work Commission Modern Award Review – *Health Professionals and Support Services Award 2010*

Key advocacy wins during 2018

General Practice

- **Funding for GP attendances at RACFs –** The AMA successfully lobbied the Government to increase funding for GPs visiting residential aged care facilities (RACFs).
- **Wound care** – The AMA's strong advocacy has resulted in the establishment of a wound management trial to run from 1 December 2019 to 30 June 2022 to test models of care for chronic wound management.
- **PIP Quality Improvement Incentive –**AMA input and representation has led to a revised scope of the previously agreed Practice Incentive Program (PIP) Quality Improvement (QI) Incentive and deferred commencement to 1 May 2019. The changed time frame means that the five Incentives (Asthma, Quality Prescribing, Cervical Screening, Diabetes, and GP Aged Care Access) that were to cease on 1 May 2018 will continue through to 30 April 2019.
- **Pharmacist in General Practice –** The AMA has strongly advocated for a Pharmacist in General Practice Incentive Program. The Government's decision to include non-dispensing pharmacists as part of the new Workforce Incentive Program delivers on that policy proposal.
- **Health Care Homes Trial –** The AMA successfully lobbied the Government for the Health Care Homes trial be extended by at least 12 months so that it can be properly evaluated. The Government has announced that the trial will now continue until 30 June 2021.

Rural Health Care

- **GP training** – The AMA has championed the expansion of prevocational training places in general practice with a focus on rural areas. Government funding for 300 additional prevocational GP training places in rural areas, as well as a commitment to fund 100 extra GP rural generalist training places, delivers on that policy proposal.
- **Support for non-VR Doctors** – The AMA has long advocated for improved support for the non-VR doctors and has welcomed Government's decision to provide incentives for doctors to qualify as vocationally recognised (VR) or specialist GPs and to practise outside major cities. Under the More Doctors for Rural Australia Program, Australian-trained non-VR doctors will be able to receive a Medicare provider number to directly bill Medicare in Modified Monash 2–7 to encourage them to practise in private practices in rural and remote areas.
- **GP Video Consultations** – The AMA welcomed an expansion of GP-to-patient telehealth services in the bush, to enable rural GPs to treat their patients over the phone or via videoconference when the tyranny of distance is impacting regular care. The AMA has long advocated for Government to extend MBS telehealth items to GP consultations for remote Indigenous Australians, aged care residents, people with mobility problems, and rural people who live some distance from GPs, to considerably improve access to medical care for these groups.
- **Rural Procedural Grants Program** – AMA advocacy has ensured continued funding of the Rural Procedural Grants Program (RPGP) and the General Practitioner Procedural Training Support Program (GPPTSP) to support rural generalist doctors to undertake training in procedural services in obstetrics, surgery, anaesthetics and emergency services in rural and remote areas.

Industrial relations

- As a bargaining agent (in conjunction with ASMOF), the AMA negotiated enterprise bargaining outcomes for members employed by the Commonwealth Department of Health.
- The comprehensive AMA National Bargaining Framework (model clause resource) was established.
- The AMA chaired NTCER discussions between GPSA and GPRA NTCER.

Medical workforce

- **A cap on medical school places** – Following strong advocacy by the AMA, the Government did not proceed with a stand-alone Murray-Darling Medical School, and is instead establishing an end-to-end rural medical school training program with the participation of existing medical schools in New South Wales and Victoria.
- **National Medical Workforce Strategy** – The AMA Medical Workforce and Training Summit called for a new National Health Workforce Strategy, the first since 2004, to enable all governments to collaborate effectively on the workforce planning, training and co-ordination need to meet Australians' future health care needs. Work on the strategy began in mid–2018, under the auspices of the National Medical Training and Advisory Network.

Doctors in training

- **Bonded medical placements** – Following extensive lobbying by the AMA, both the Bonded Medical Places (BMP) and Medical Rural Bonded Scholarship (MRBS) programs will be radically overhauled. These changes will effectively standardise conditions for bonded medical graduates, moving away from the current contract-based arrangements.

The reformed arrangements will apply to all new participants from January 2020. In addition, existing BMP and MRBS participants will be able to opt in to the new arrangements once they are in place, including in circumstances where they are already part-way through meeting their current Return of Service (ROS) obligations.

- **National Training Survey** – The Medical Board of Australia has committed to developing and implementing a National Training Survey (NTS) after sustained AMA advocacy. The AMA has representatives on both the NTS steering committee and advisory group which will oversee the development and implementation of the NTS.

  The NTS will provide more timely and comprehensive data on the quality of the medical education and training experience to inform workforce and medical training policy, planning, and practice. Importantly, it can also be used to evaluate the impact of policy change in this area.

- **Support for trainees affected by exam disruptions** – The AMA played a strong role in working with the Royal Australasian College of Physicians (RACP) to ensure that trainees affected by the failure of the Computer Based Basic Training Written Divisional Exam were supported through a very difficult time. The AMA's response was immediate and effective with its priorities being to ensure that:
  - trainees in distress understood what support options were available to them, including through local doctors' health advisory services;
  - trainees had a fair opportunity to complete the replacement examination without financial penalty or negative impact on training progression; and
  - reasonable compensation was provided to trainees who incurred significant costs as a result of the exam cancellation.

  With additional technical difficulties experienced during the RACGP computer-based written examinations several months later, guidance around management of examination disruptions has been added to AMA policy on vocational training assessment.

- **Progress toward a National Hospital Health Check** – Originally developed in Western Australia, now several State and Territory AMAs/Doctor in Training Committees (DiTCs) run annual Hospital Health Checks to measure and report on how well health services are meeting State-based industrial agreements, accreditation standards, or other issues of importance for doctors in training.

  The AMACDT has developed a standardised set of questions to allow every State and Territory AMA to run a Hospital Health Check, with the option to add additional local questions, to measure and report on how well health services are meeting the needs of doctors in training.

  The advocacy potential of this project has been proven at a State level, and standardised questions will provide a nationally comparable dataset despite different State industrial agreements. It will be an essential tool to enable the AMA to advocate for change in key areas for all DiTs.

- **Advocacy to achieve gender equity in the workplace** – Action on gender inequity in medicine is a priority for the AMA following on from the Federal Council endorsement of two motions on achieving gender equity passed at the 2018 AMA National Conference.

  The AMA was planning for a Gender Equity Summit in March 2019. It will consider the root causes and practical solutions, including drawing on experiences outside medicine, to make the changes necessary within our systems and culture to achieve gender equity in our medical profession and workplaces.

Doctors' Health

- The AMA, through its subsidiary company Doctors' Health Services Pty Ltd, 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. The 2015 agreement between the AMA and the Board for funding doctors' health programs was extended for a further three years in March 2018 until 2021.

8.

Medical Practice

Private Health Insurance

To ensure that Australia maintains its strong and viable private health sector, the AMA has been calling on Government to bring much-needed transparency, clarity, and affordability to the private health sector. 2018 saw the passage through the Commonwealth Parliament of anticipated reforms to Private Health Insurance.

The AMA has worked hard with Government to ensure these reforms put value back into private health insurance for patients and doctors. The AMA continued to be represented on Private Health Ministerial Advisory Committee and its many subcommittees in 2018, including improved models of care for rehabilitation and mental health, risk equalisation, clinical terminology, and out-of-pockets.

The AMA prepared detailed submissions to the Department of Health on the draft standard clinical definitions for private health insurance policies, as well as on the draft private health insurance rules. In addition, the AMA prepared a comprehensive submission to the Senate Committee inquiry into the private health insurance legislative amendments, with the President and Chair of the Council of Private Specialist Practice later appearing in front of the Senate.

Throughout the year, the AMA worked hard to ensure that the discussion on out-of-pocket costs is broadened beyond doctors' fees. The AMA has continually highlighted that 95 per cent of services in Australia are currently provided at a no-gap or a known gap of less than $500, and that medical costs make up only 21 per cent of out-of-pocket expenses.

The AMA was represented on the Ministerial Advisory Committee on Out-of-Pocket Costs, and several AMA Federal Councillors (including the President) took part in a high-level policy round table on price and performance transparency hosted by the Consumers Health Forum of Australia and the Centre for Health Policy University of Melbourne with the support of the Medibank Better Health Foundation, among other key activities.

Private Health Insurance Report Card

The AMA again launched the AMA Private Health Insurance Report Card – providing consumers with clear, simple information about how health insurance really works.

Like previous reports, the 2018 report demonstrated the complexity of navigating private health insurance products in 2018. The AMA's continuous scrutiny and analysis of the carve-outs, exclusions, and caveats proliferating through this industry have contributed to the Government's review of private health insurance and to the development of the new Gold, Silver, Bronze, and Basic products.

The report also highlighted the bewildering array of policies on offer, which provide significantly varying levels of cover, gaps, and management expenses. The Report Card provides an example of a common item – to demonstrate what different insurers may cover, what the MBS covers, and what an out-of-pocket fee may be under different scenarios.

The report also highlights that private health insurer benefits vary significantly between policies and insurance companies. Benefits vary by State, and the AMA has again highlighted the percentage of hospital charges covered by State and fund – to help the consumer better understand what they are buying.

There has been a lot of talk in the last year about the role of doctors in out-of-pocket costs. Private health insurance needs to 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. But insurers also need to be transparent about their rebates. To determine an out-of-pocket cost, patients need to know what rebates they will receive from their health insurers and, as the AMA Report Card shows, some are certainly far better than others.

Medical Indemnity

The review into the Indemnity Insurance Fund (IIF) and each of the schemes that comprise the IIF – known as the Medical Indemnity Scheme – continued throughout the year. The AMA was represented at each of the more than half-a-dozen Medical Indemnity Workshops held. The 2018/19 Mid-Year Economic and Fiscal Outlook (MYEFO) saw the welcome announcement by the Government that it had accepted the key recommendations of the review report and was supporting the continuation of the Medical Indemnity schemes without significant cuts.

This was a good outcome for the medical profession, which had 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.

The Government has accepted the recommendations of the Review to streamline and simplify the administration of the schemes. Changes to both the legislation and regulations are planned for early 2019.

National Registration and Accreditation Scheme for Health Practitioners

The AMA lodged a submission to the Council of Australian Governments (COAG) Health Council in response to the consultation paper, *Regulation of Australia's health professions: keeping the National Law up to date and fit for purpose*.

In its submission, the AMA expressed deep disappointment that the opportunity to really evaluate the effectiveness of the National Registration and Accreditation Scheme had been squandered. The consultation document provided did not analyse the effectiveness of the scheme, but rather offered a grab bag of ideas and accumulated thoughts. The AMA has grave concerns that, if implemented, many of the proposals would have a significant negative effect on the scheme as it currently operates and on a practitioner's career and well-being.

There were some proposals in the consultation document that would make the current system more efficient and workable (including some proposed by the AMA) and the AMA supported implementation of these recommendations. However, it was disappointing that many of the suggestions put forward were unworkable, regressive, and some a further rehash of previously debunked proposals. The discussion paper raised the issue of appointing a non-practitioner as Chair of the Medical Board again, and again the AMA strongly opposed this idea.

Medicines and TGA activities

In the interests of ensuring its policies are sound and current, the AMA updated and released its Position Statement on Complementary Medicines, which encompasses both medicines and the practice of complementary therapies.

The AMA engaged with the Therapeutic Goods Administration (TGA) in 2018 regarding a wide range of medicines and devices, and regulatory and safety issues.

The AMA contributed to, and supported, the development and implementation of a new mandatory medicines shortages notification system to allow shortages of critical medicines to be better managed and communicated.

However, several submissions were lodged opposing the Government's decision to allow advertising of Schedule 3 (pharmacist only) medicines directly to the public, highlighting the risks to public safety. While some additional medicines may now be advertised, AMA advocacy contributed to the majority remaining as medicines for advertising to health professionals only.

Increasing deaths and illness due to misuse of opioids continued to cause concerns. AMA representatives participated in stakeholder meetings to discuss further regulatory measures that could help reduce opioid misuse, as well as lodging a detailed submission on potential options.

In April, the AMA President attended a meeting of the TGA Consultative Committee, a high-level stakeholder group providing feedback on the TGA's key projects, and was also invited to attend two meetings of the TGA's Advisory Committee on Medicines Scheduling to provide advice on specific scheduling proposals. The AMA lodged submissions opposing scheduling proposals from pharmaceutical companies that would allow Sildenafil and Nabiximols to be purchased over the counter without a prescription. The TGA subsequently denied these proposals.

All medicine-related submissions are published on the AMA's website at https://ama.com.au/policy/submissions.

Scopes of practice – nurses, pharmacists, and midwives

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 Nursing and Midwifery Board is seeking to extend prescribing to all registered nurses. An AMA submission early in 2018 discouraged the Board from its initial proposal to expand nurses' scope of practice to independent prescribing. The AMA lodged a further submission in response to the Board's current proposal for all registered nurses to be able to apply for endorsement to prescribe under the supervision of a medical practitioner or nurse practitioner. The AMA values the expertise and contribution of nurses and midwives in providing health care services and caring for patients, but prescribing by non-medical health professionals is a risk to patient safety unless medically-led.

Pharmacists are also seeking to prescribe medicines in order to broaden their professional and commercial base. The AMA participated in a stakeholder consultation workshop facilitated by the Pharmacy Board of Australia and strongly opposed pharmacist prescribing in a community pharmacy setting, highlighting the inherent conflict of interest of prescribing while dispensing for commercial gain. Federal AMA also assisted AMA Queensland to lobby against a Queensland Government proposal to allow pharmacist prescribing, despite a COAG agreement requiring a proscribed process overseen by AHPRA.

The AMA continued to engage in the development of a new national public sector maternity services strategy through membership of a professional advisory group and by attending consultation workshops held throughout Australia. Two detailed submissions were also lodged highlighting the central role of medical practitioners in the care of women and their babies. Obstetrician or GP obstetrician-led maternity services provide the best outcomes for mothers and babies, and midwives must work within these collaborative models.

Diagnostic imaging

Recognising a gap in its formally agreed policies, the AMA developed a comprehensive *Position Statement on Diagnostic Imaging.* The Position Statement covers key issues relating to the funding, regulation, quality, and safety of diagnostic imaging in Australia today.

The AMA continued to participate in the primary stakeholder committee providing advice to the Department of Health on regulatory and funding matters relating to diagnostic imaging services funded under Medicare.

The Department consulted the AMA separately on the introduction of minimum qualifications for medical practitioners performing ultrasound services in order for those services to be subsidised by the Government.

The AMA lodged a submission supporting a draft code developed by ARPANSA on minimising exposure to radiation through medical imaging, but emphasised the importance of training for all medical practitioners on the use and dangers of radiation.

Mandatory Reporting

This year has seen the AMA working hard advocating strongly for changes to the mandatory reporting laws.

The current mandatory reporting provisions put both doctors and patients at risk by deterring 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.

In April 2018, Dr Gannon outlined the AMA's key concerns in an unprecedented address directly to all Health Ministers at the COAG Health Council. In response, the Health Council approved a targeted consultation process for proposed amendments to mandatory reporting requirements by treating practitioners. The AMA provided a submission in August 2018, but was disappointed when Health Ministers ignored the substantial issues.

The unrevised amendments were introduced to the Queensland Parliament in November 2018. Again, the AMA lobbied hard to have these amendments improved. The amendments were referred to a Parliamentary Committee. The AMA provided a further submission and Drs Bartone and Dupelia addressed the committee directly. Unfortunately, despite many medical groups supporting changes to the amendments, the Parliamentary Committee did not support further amendments to the National Law.

The Queensland Parliament is due to vote in early 2019 to amend the legislation according to the decision of COAG Health Ministers. The AMA will continue to lobby on this issue to ensure that barriers discouraging doctors from seeking help from other doctors are removed. The AMA has already commenced lobbying the Australian Health Practitioner Regulation Agency (AHPRA) to ensure that it produces a strong set of guidance and educational material that clearly demonstrates how doctors will not be reported when being treated as a patient.

Medicare Benefits Schedule (MBS) reviews

The AMA responded to every single MBS Review consultation in 2018, mainly raising broader strategic, process, and policy issues identified by Council representatives, members of the AMA MBS working group, the wider membership and through engagement with the relevant Colleges, Associations, and Societies. The AMA also provided feedback on clinical aspects where members identified significant concerns.

The Federal AMA MBS Review webpage went live in mid–2018 and provides AMA members (and the public) with a one-stop bulletin board on AMA's engagement and advocacy with the MBS Reviews. All the AMA's submissions are published on the website at https://ama.com.au/mbs-reviews.

The AMA also lobbied for all Taskforce reports to be made publicly available to improve transparency and boost stakeholder engagement. In December 2018, the Department published all the MBS Review Clinical Committee reports dating back to the commencement of the Review in 2015.

The AMA also successfully urged the Taskforce to extend deadlines for responses on the 29 MBS Review reports (including sub-specialty reports) released for targeted consultation in late 2018, to ensure proposed changes are based on robust clinical and profession feedback.

Subsequent attendance item

In November 2017, co-claiming restrictions and new arrangements were imposed that resulted in removal of a consultation item for an unplanned consult that occurs after a planned procedure of over $300, even if the consult and procedure are unrelated.

The AMA identified this error and is subsequently working closely with the Department of Health to rectify this unintended consequence of the co-claiming restriction.

Implementation of new spinal surgery items

The AMA met with the Chair of the MBS Spinal Surgery Clinical Committee to develop methodology to derive an accurate fee for the AMA Fees List. Following pressure from the AMA, the Department of Health held a meeting in December 2018 with all key insurers to explain the methodology behind the new spinal surgery items and benefit changes.

The key issues were that the implementation of these items did not provide enough time for insurers to adapt, did not provide any insights as to why the changes were made and how the fees were derived, to inform insurers in the development of their benefit schedules. The outcome is that most insurers were not ready for a number of weeks to provide rebates, and that practices could not bill. Once insurers put in place their rebates, there appeared to be some cuts to the rebates, which could potentially be attributed to the implementation process.

As a result of the AMA's advocacy, the Department is reconsidering MBS implementation processes, timeframes, and support to insurers and the profession going forward.

MBS Compliance

Compliance briefings

In 2018, AMA representatives attended a number of Department of Health compliance stakeholder briefings, where data analytics undertaken by consultants on behalf of the Department was presented. The data analytics identifies doctors who have claimed above the 90th percentile compared to their peers, and targeted education letters are generated and sent to these doctors. The AMA represented concerns from the profession at these briefings, including the need to better account for clinical appropriateness and

context. The AMA was also active in acting as conduit between the Department to communicate compliance monitoring activities to the professions and relaying profession concerns from the relevant craft groups.

Compliance education

The AMA advocated and continues to do so on behalf of members for improved compliance education which consists of the following:

- real education without unwarranted threat of punishment and unnecessary obligations to audit own records;
- consistent and accurate advice by AskMBS —linked to policy intent of items and well trained staff;
- MBS changes (including MBS Review implementation) to be communicated directly from the Department to affected medical practitioners; and
- coordinated compliance education between all related areas of the Department, e.g. MBS Review, policy, compliance monitoring and education, and Professional Services Review (PSR).

Professional Services Review (PSR)

PSR Scheme

The AMA continues to actively advocate for fair and transparent processes of the PSR Scheme.

Panel appointments

The AMA endorsed 19 panel members or deputy director appointments to the PSR from the following specialties: dermatology; haematology; general practice; rheumatology; rehabilitation, sport, respiratory and sleep physicians; colorectal surgery; and obstetrics and gynaecology.

AMA Fees List

From 1 November 2018, a single indexation of 2.10 per cent was applied across all AMA fees, compared to 1.86 per cent the year before. The AMA Travel charge increased from $3.30 to $3.40 in 2018.

The AMA Fees List item descriptors and/or fees were updated in response to changes to MBS items due to MBS Reviews or other mechanisms, in consultation with College, Association, and Society organisations.

2018 was a successful year in the transition of the AMA Fees List to a fully online model. This has allowed the AMA to update items in a timelier manner, which is increasingly critical now the MBS Review is underway. It has also allowed the AMA to add additional features for members, a more streamlined purchasing model, and saved a significant amount of printing and waste.

Public hospital funding

The AMA maintained its strong advocacy on public hospital funding throughout 2018, using data published by the Australian Institute of Health and Welfare (AIHW) to produce the 2018 AMA Public Hospital Report Card. The AMA Report Card assesses the performance and capacity of our public hospitals to meet the community's need for hospital services, and provides an insight into the experiences of the AMA doctors who work there.

The report highlights the funding and demand pressure on our public hospitals. Growth in Federal and State government funding is tracking at 2.8 per cent and 3.2 per cent per annum respectively, over five years to 2015–16, and 4.3 per cent over the decade.

The Report Card focused the spotlight on this very low level of public hospital funding growth, while public hospitals continue to treat more and more patients each year. Over the five-year period between 2011–12 and 2015–16, public hospital separations rose on average by 3.3 per cent per annum, more than double the average population growth of 1.6 per cent per annum over the same period.

Demand pressure on public hospital emergency departments continued to rise. In 2016–17, overall waiting times got longer and a third of the 2.8 million patients who presented to emergency in need of urgent treatment were not seen within recommended timeframes.

Elective surgery performance in 2016–17 was mixed. The median wait time for all categories of elective surgery got longer, continuing the long-term trend in the wrong direction. Performance on urgent elective surgery was mixed. Some jurisdictions improved the proportion of urgent patients admitted within the clinically recommended 90 days. Other jurisdictions struggled.

The AMA President called on governments to lift public hospitals out of their long-term funding crisis, reverse the penalty-based safety and quality agenda and, importantly, called for increased funding across the whole health system, including more investment up-stream on prevention, general practice, and private health to take demand pressure off the public hospital system.

During 2018, the AMA also provided submissions to the Independent Hospital Pricing Authority (IHPA) and

participated in IHPA working groups to ensure IHPA understands the impact the current public hospital activity-based funding formula has on patients and the doctors who treat them.

My Health Record

The AMA has a long history of supporting the My Health Record. The Record has the potential to effectively circumvent the limitations of localised clinical record storage and ensure important patient information is available at the point of care, irrespective of the health care setting and the location of the treating doctor. The benefits accrue to the patient and the treating medical practitioner, creating better connected care and reduced medical harm, especially from avoidable medication complications and allergic reactions.

The My Health Record could also deliver health system efficiencies. As the Record matures, and is taken up by patients and healthcare providers, there should be less need to duplicate medical treatments such as diagnostic and pathology tests whenever identical test results are visible in the patient's record.

In 2018, the basis for participating in the My Health Record changed from an opt-in to an opt-out arrangement. In the lead-up to the opt-out period starting 16 July 2018, the AMA worked closely with the Australian Digital Health Agency (ADHA) to improve the useability and utility of the My Health Record for clinicians. AMA members were represented on, and contributed to, multiple steering groups including the My Health Record Expansion Program Steering Committee, the Diagnostic Imaging Program Steering Group, and the Pathology Program Steering Group.

During the second half of 2018, the AMA also worked closely with the Government to strengthen privacy protections in the *My Health Record Act 2012* (the Act). In particular, the AMA secured amendments to prohibit the ADHA from future disclosure of My Health Record data to a law enforcement body without a warrant or judicial order. To further strengthen the privacy of patients who do not want their data stored in the My Health Record, the AMA negotiated an amendment to require the ADHA to permanently destroy all clinical information in a patient's My Health Record if the person requests their record to be cancelled.

During the opt-out period, a Senate Community Affairs References Committee Inquiry into the My Health Record System was established. The AMA submission to this inquiry is available at https://ama.com.au/submission/ama-submission-my-health-record-community-affairs-legislation-committee-inquiry-my-health-record. AMA representatives appeared before this Committee on 11 September 2018 to discuss the issues raised in the submission. A separate Inquiry to examine the *My Health Record (Strengthening Privacy) Bill 2018* was also initiated. The AMA submission to this inquiry is available at https://ama.com.au/submission/ama-submission-my-health-record-community-affairs-legislation-committee-inquiry.

As a result of AMA advocacy behind the scenes, via submissions and during the AMA's appearance at the inquiry, one of the amendments that passed the Parliament elevates the Framework for the Secondary Use of My Health Record Data from a policy document into the *My Health Record Act 2012*.

My Health Record will need to continue to mature and evolve over time, and AMA advocacy into the future will remain important.

Aged care

2018 continued the trend of significant aged care system reviews and inquiries, including the announcement of a Royal Commission into Aged Care Quality and Safety (the Royal Commission). The AMA lodged 11 submissions regarding different aspects of the quality of aged care, appeared at three Parliamentary hearings, and produced two aged care Position Statements.

The Royal Commission was announced in October. The AMA welcomed its announcement and called for additional Terms of Reference, including a focus on the quality of clinical care, medication management, mental health, end of life care, and the use of restrictive practices. The AMA's submission to the Department of Health on the Royal Commission's Terms of Reference is available at https://ama.com.au/policy/submissions.

Additional funding for aged care was announced under the 2018–19 MYEFO in December. This included $98 million for GP services in residential aged care facilities (RACFs), $287.3 million to fast-track 10,000 high-level home care packages, and a new MBS item for mobile radiology services in RACFs (part of $58.9 million in new and amended MBS items). The AMA extensively advocated for additional funding in all three of these areas. See, for example, the AMA's submission to the Medical Services Advisory Committee on new mobile radiology services at https://ama.com.au/submission/ama-submission-medical-services-advisory-committee-%E2%80%93-new-mobile-imaging-services.

The AMA lodged a submission to the Senate Community Affairs Legislation Committee *Inquiry into the Aged Care*

Quality and Safety Commission Bill 2018 and related Bill. Dr Bartone and AMA Council of General Practice (AMACGP) Chair Dr Richard Kidd represented the AMA at a public hearing for this inquiry. Following strong AMA advocacy, the Aged Care Quality and Safety Commission's Chief Clinical Advisor position was enshrined in legislation. The Department of Health confirmed that the Chief Clinical Advisor will be a medical practitioner.

AMA submissions to House of Representatives Standing Committee on Health, Aged Care and Sport for the *Inquiry into the quality of care in residential aged care facilities in Australia*, the Department of Health's *Aged Care Workforce Strategy Taskforce* (ACWST), and the Senate Community Affairs References Committee Inquiry on the *Effectiveness of the Aged Care Quality Assessment and accreditation framework* (supplementary submission) reiterated the AMA's main arguments to improve quality in aged care. That is, many of the current causes of inadequate quality care in RACFs can be rectified by improving the capability, capacity and connectedness of the aged care workforce. A lack of support for doctors has resulted in an enormous barrier to quality medical services for RACF residents. Dr Bartone reiterated these arguments at the second Summit for the ACWST, and at a public hearing for the House of Representatives inquiry, along with Dr Kidd. The report to the House of Representative's inquiry adopted several of the AMA's recommendations, including that the MBS rebates for medical practitioner visits be reviewed, and to legislate 24-hour registered nurse availability.

The AMA made a submission to the Standing Committee on Health, Aged Care and Sport *Inquiry into the Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018*. The AMA argued that while the Bill was a good first step, aged care needs mandatory minimum staff-to-resident ratios that reflects the level of care needs and ensure 24-hour registered nurse availability. These points were reiterated by AMACGP members Dr Simon Torvaldsen and Dr Kean-Seng Lim (also AMA NSW President) at a public hearing. The Committee agreed with the AMA that further contextual data such as level of care need was required, and that minimum registered nurse levels should be legislated.

The AMA argued in its submission to the Aged Care Quality Agency that the guidance document for the new Aged Care Quality Standards sets out good principles for aged care services. The next step is to provide guidance on how the new standards will be implemented, and to provide the funding for adequately trained staff to be able to meet the standards while still providing quality care to their consumers.

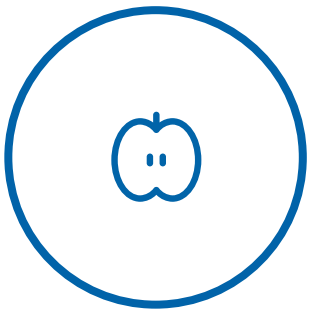
The AMA in its submission to the Department of Health on the draft Charter of Aged Care Rights stated that the Charter sets out good, clear principles towards communicating older consumers' (and their family's and carer's) rights when accessing Commonwealth-subsidised aged care services. The AMA argued that more detail should be provided through easy-to-understand and accessible guidance documents.

In its submission to the Aged Care Financing Authority on respite care, the AMA argued that current access to respite care is neither timely nor responsive to the needs of older people. Significant delays and access shortages persist, often leaving admission of the older person to hospital as the only option, if the carer is unable to cope.

The AMA highlighted in its submission to the Department of Health on Specialist Dementia Care Units (SDCUs) that RACFs should not rely heavily on this program as a substitute for improving dementia management in usual RACF settings. Issues with the current aged care services, and the system as a whole, need to be rectified in order to prevent people living with dementia deteriorating to such severe levels of behavioural distress that they require SDCUs.

9.

Public Health



Nutrition – 2018

In 2018, the AMA revised its Position Statement on *Nutrition*, as nutrition is a key determinant of health and an important public health issue. Poor nutrition is a significant contributor to non-communicable diseases. Despite many Australians having access to high quality fresh foods, most do not consume these in the recommended amounts. Instead, more than one-third of food intake comes from highly processed foods and beverages, commonly referred to as junk foods. There is ongoing concern about the health implications of a diet high in refined and added sugar. The Position Statement articulated the AMA's support for proposals to apply a tax or levy to sugar-sweetened beverages in Australia in order to reduce consumption.

While governments are often hesitant to intervene and support measures that may impact on industry, increasingly poor nutrition and the resulting costs to the Australian healthcare system are consuming precious resources.

The Position Statement also called for continued expansion of Health Star Rating (HSR) front-of-pack food labelling, healthy foods to be provided in all healthcare settings, regular review and updating of national dietary guidelines, increased investment into evidence-based policy responses to food insecurity, and the cessation of the targeted marketing of junk food to children.

Following the release of the Position Statement, the AMA continued its advocacy on nutrition issues. The AMA provided a submission to a Review of Fast Food Menu Labelling Schemes, which highlighted the need to increase understanding of daily energy needs and to lower the threshold for mandatory labelling requirements. The AMA advocated for improved food labelling in a number of consultations, including those regarding fast food menu labelling, added sugar labelling, and the five-year review of the Health Star Rating System. Professor Geoff Dobb continued to represent the AMA on the Health Star Rating Advisory Committee.

Nutrition Working Group: Dr Tony Bartone (Chair), Dr Richard Kidd, Dr Janice Fletcher, Dr Shaun Rudd, Prof Geoffrey Dobb, Dr Katherine Gridley (DiT).

Road Safety – 2018

The Position Statement on *Road Safety – 2018* followed ongoing AMA promotion on road safety issues, including submissions to Parliamentary inquiries into road safety, and engaging in ongoing dialogue with motorist and road safety stakeholders. This Position Statement covered the main issues around road safety, including speeding, driver fatigue, driver distraction, alcohol and substance abuse, risk taking behaviours, pedestrians, bicycles, and driver training, as well as unsafe roads and unsafe vehicles. The AMA emphasised driver training, and called for tougher penalties for drivers using electronic devices. Our call for tougher penalties for P and L-plate drivers who break road rules was well received by motoring groups and gained national media coverage.

The Position Statement was released in January 2018 and received a significant amount of media attention over the Christmas-New Year period. Advocacy on road safety issues continued throughout 2018, including a submission to the Department of Infrastructure, Regional Development and Cities' Inquiry into the *National Road Safety Strategy 2011–2020* and AMA representation at Ministerial meetings on road safety.

Road Safety Working Group: Dr Bill Boyd (Chair), Dr Michael Gannon, Dr Shaun Rudd, Dr John Zorbas (DiT).

Mental Health – 2018

Mental health is a very complex and contested area of health care, and an enormous subject that was difficult to cover in a single document. The Position Statement on *Mental Health – 2018* outlined the imbalance in funding, the reforms being undertaken and the need to see mental health within wider societal issues. The main issues covered include service delivery and funding, coordination, workforce and infrastructure, prevention and education, and e-health and telemedicine. This Position Statement provided the AMA with an advocacy platform and a clear sense of what is needed to meet the needs of people with mental health problems. It was very well received by the mental health sector and led to increased engagement by the AMA in this critical area of health care.

Mental health impacts on almost every aspect of health care. AMA advocacy in 2018 included regularly engaging with key sector stakeholders, such as drug and alcohol organisations, mental health nurses, peak mental health NGOs, and leading advocates. The AMA Psychiatrists Group (AMA PG) also convened during 2018 and produced an extensive newsletter. Federal AMA is also liaising with AMA Victoria on the forthcoming Victorian Royal Commission into Mental Health and commenced work on a substantial submission to the Productivity Commission Inquiry into Mental Health.

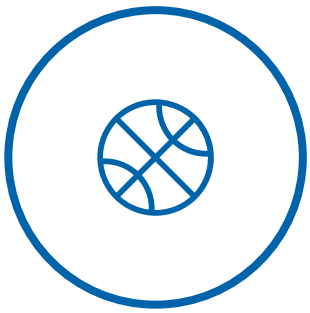
Mental Health Working Group: Dr Tony Bartone (Chair), Dr Richard Kidd, Prof Steve Kisely, Dr Sandra Hirowatari, Mr Rob Thomas (AMSA).

National Disability Insurance Scheme – 2018

A new Position Statement on the *National Disability Insurance Scheme – 2018* was released in April 2018. The Position Statement explained the roles and functions of the National Disability Insurance Scheme and the National Disability Insurance Agency (NDIA) and outlined eligibility for NDIS funding. It set out a number of positions across six areas: general principles; mental health; planning and assessments; funding; Aboriginal and Torres Strait Islander people; and rural and remote.

National Disability Insurance Scheme – 2018 called for bipartisan commitment to fund the NDIS, and stressed the importance of diagnoses and reports from medical professionals being respected by appropriately qualified NDIS planners. It also recommended that medical practitioners and participants be appropriately informed about the scheme, that the circumstances leading to permanent psychiatric impairment not be grounds for ineligibility, that NDIS services be culturally appropriate, and that the NDIS address Indigenous housing as a priority. The Position Statement was drafted following a policy session of the AMA Federal Council in November 2017. The Council for General Practice, the Medical Practice Committee, and the AMA Psychiatrists Groups then reviewed the statement.

The AMA's advocacy on the NDIS was significant and led to closer engagement with the NDIA. The AMA met with a number of NDIS providers and discussed NDIS issues with the Minister for Health's advisers. In November, Dr Bartone represented the AMA at the 2nd Annual National Mental Health and NDIS Conference, where he outlined the AMA's position.



Drugs in Sport – 2018

The revised Position Statement on *Drugs in Sport – 2018* was released in April, to coincide with the opening of the XXI Commonwealth Games on the Gold Coast. The previous Position Statement was released in 2000, around the same time as the Sydney Olympic Games. Since this statement was released, there has been significant media attention on the use of drugs in sport and the revised Position Statement reflects developments in doping substances and tests.

Drugs in Sport – 2018 provided context, explained performance and image enhancing substances, and outlined methods used to create an unfair advantage over other competitors. It emphasised that performance-enhancing substances have negative health consequences and that anti-doping policies and education are vital. Importantly, it provided advice to medical practitioners in terms of how they can best prevent the use of performance-enhancing drugs by athletes. This includes using checking tools when prescribing medications to athletes, being aware of potential conflicts of interest between individuals and teams, and making sure athlete patients are aware of their obligations. Following its release, *Drugs in Sport – 2018* was circulated to all Federal Parliamentarians, accompanied by a letter highlighting the need to protect the integrity of all levels of competitive sport in Australia.

Drugs in Sport Working Group: Dr Robyn Langham (Chair), Dr Shaun Rudd, with expert input from the Australian Sports Anti-doping Authority, Dr Andrew Jowett and Dr Susan White.

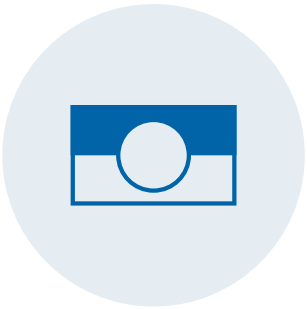
Men's Health – 2018

The AMA's updated Position Statement on *Men's Health – 2018* was released in April. Australian men enjoy relatively good health outcomes, but still have a shorter life expectancy than Australian women, and have a higher mortality rate for most major causes of premature death. The Position Statement outlined barriers for men in accessing the health system, specific areas of concern such as cancer screening and mental health, and vulnerable populations including men in rural and remote areas, and culturally and linguistically diverse men. Primarily, the Position Statement called on the Federal Government to develop a National Men's Health Strategy. It also called for flexible and responsive health services and emphasised the importance of general practitioners for men's health.

Following the release of *Men's Health – 2018*, the Federal Government announced the development of a National Men's Health Strategy to cover a 10-year period from 2020. The AMA welcomed this news and provided formal and informal feedback to the development of the Strategy, which is due to be released in early 2019. Dr Bartone also attended the National Men's Health Forum in August as part of this consultation. In November, Dr Kath Carmo represented the AMA on a Men's Health panel discussion at the National Men's Health Gathering.

Men's Health Working Group: Dr Tony Bartone (Chair), A/Prof Rob Parker, Dr Lorraine Baker and Dr John Zorbas.

Advocating on Public Health Issues



Indigenous Health

The AMA released its 2018 Report Card on Indigenous Health, *Rebuilding the Closing the Gap Health Strategy and a Review of 2016 and 2017 AMA Indigenous Health Report Card Recommendations,* in November. The Closing the Gap (CTG) strategy was launched in 2008, yet the target to close the gap in life expectancy between Indigenous and non-Indigenous Australians by 2031 is not on track, the gap is widening. In order to increase the life expectancy of Aboriginal and Torres Strait Islander peoples, the AMA called on the Federal Government to rebuild the strategy from the ground up and make a real commitment for its implementation. This year's Report Card emphasises issues including:

- equitable needs-based funding;
- systematically costing, funding, and implementing the 'Closing the Gap' health and mental health plans;
- identifying and filling the gaps in primary health care;
- addressing environmental health and housing;
- addressing social determinants; and
- Aboriginal leadership.

The Report Card highlighted the practical recommendations required to achieve CTG targets and guide the CTG 'refresh' process. Dr Bartone launched the Report Card at the Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) in Brisbane in November.

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. The alliance is working on developing a Roadmap which outlines a stepped approach to eliminate RHD. After making submission to DOH it will go through COAG in first quarter of 2019.

The AMA Indigenous Medical Scholarship supports more Aboriginal and Torres Strait Islander people to become doctors. Applications for the 2019 Indigenous Medical Scholarship opened on November 1, 2018. The winner will be announced at the 2019 AMA National Conference in May. Plans are underway for a self-service portal to enable members and the general public to make online payments using their credit card for donations towards the Scholarship.

The AMA continued to be an active member of the Close the Gap Steering Committee and to contribute to the Close the Gap campaign. The AMA provided in-principle support to the Strategic Engagement Priorities paper produced by the Close the Gap Steering Committee (CTGSC).

The AMA advocated for Aboriginal and Torres Strait Islander people through submissions to public consultations on key documents. In September 2018, a submission was lodged with the Aboriginal and Torres Strait Islander Health Reference Group (A&TSIHRG) of the MBS Review Taskforce in relation to the recommendations for the in-scope MBS items. The recommendations cover the following areas:

- mental health;
- chronic conditions management;
- substance misuse rebate items; and
- Aboriginal health checks.

The AMA also made a submission in September 2018 to the Australian National Audit Office (ANAO), regarding the performance audit of Closing the Gap in Indigenous Disadvantage and to assess the effectiveness of the arrangements established by the Department of the Prime Minister and Cabinet and the Productivity Commission for monitoring, evaluating, and reporting progress towards Closing the Gap in Indigenous Disadvantage.

Obesity

The AMA continued its extensive advocacy on obesity issues in 2018. In collaboration with the Heart Foundation, the Confederation of Australian Sport, and the Australian Health Policy Collaboration, the AMA advocated for a National Physical Activity policy.

In June, the AMA made a submission to the Senate's Select Committee into the Obesity Epidemic in Australia, which called for a National Obesity Strategy, a whole-of-society approach, and the implementation of a sugar tax, among other measures. Dr Bartone appeared at a public hearing of the committee in September, and raised a number of issues, including the role of GPs in obesity management, environmental factors relating to weight, the merits of a sugar tax, and the need for public access to bariatric surgery. The AMA welcomed the COAG Health Council's announcement in October of the development of a National Obesity Strategy, and will monitor its progress going into 2019.

Alcohol and Alcohol-related Harm

Alcohol remained a key topic for AMA advocacy in 2018. In January, the AMA provided formal feedback on the Consultation Draft of the *National Alcohol Strategy 2018–2026*. The submission expressed frustration at the lack of tangible strategies and accountability measures, and questioned the value of including unimplemented initiatives from previous strategies. AMA Vice President, Dr Chris Zappala, also represented the AMA at a roundtable on the Strategy hosted by the Ministerial Drug and Alcohol Forum in July.

The AMA continued to engage with alcohol industry groups, including meeting with Carlton and United Breweries to provide advice on their Fetal Alcohol Spectrum Disorder campaign, and encouraging DrinkWise to retract misleading communications regarding the safe consumption of alcohol during pregnancy.

The AMA also emphasised support for mandatory, clear, consistent, front-of-pack pregnancy warning labels in a submission to Food Standards Australia and New Zealand's targeted consultation on pregnancy warning labels for alcoholic products. State and Territory AMAs lobbied the Ministerial Forum on Food Regulation on this issue, which subsequently decided to mandate warning labels.

Tobacco

Tobacco has long been a key advocacy topic for the AMA and remained so in 2018. Early in the year, the AMA co-signed Cancer Australia's statement *E-cigarettes in Australia*, which called for a precautionary approach to e-cigarettes and emphasised the need for further research into e-cigarette safety. In March, the House of Representatives Standing Committee on Health and Aged Care released the report of its *Inquiry into the Use and Marketing of Electronic Cigarettes and Personal Vaporisers in Australia*. Encouragingly, the report echoed the AMA's advice to the Committee, noting the lack of evidence that e-cigarettes are effective cessation aids.

Dr Gannon met with Professor Anne Kelso, the CEO of the National Health and Medical Research Council (NHMRC), to discuss research into e-cigarettes and potential policy responses. The AMA also participated in the development of the next iteration of the National Tobacco Strategy, with Secretariat attending a roundtable discussion in August.

In September, Federal Health Minister Greg Hunt announced a further inquiry into the scientific evidence around e-cigarette use, to be conducted by the National Centre for Epidemiology and Population Health. The AMA has been involved in briefings on the scope and approach of this inquiry and will continue to engage with the NCEPH when relevant.

Addiction

The AMA released a Position Statement on *Harmful Substance Abuse, Dependence, and Behavioural Addiction (Addiction)* in 2017, and continued to publicly discuss addiction issues in 2018.

The AMA made submissions to Senate enquiries related to substance use. The AMA's submission relating to the *Social Services Legislation Amendment (Drug Testing Trial) Bill* voiced concerns about the consequences of such a trial and emphasised that substance dependence is primarily a health issue. The AMA also provided a submission relating to removing restrictions on cannabis, which expressed support for efforts to stop incarceration related to cannabis use, but cautioned that efforts to decriminalise cannabis may be detrimental to some groups within the population.

In November, the AMA participated in a consultative stakeholder forum canvassing options for a National Treatment Framework for Alcohol and Other Drug services, to be released in 2019. Key points included the importance of clear referral pathways for drug and alcohol services, and the need for evaluation of the Public Health Network-delivered Alcohol and other Drug Treatment model.

Climate Change

Tackling climate change has been described as "the biggest global health opportunity of the 21st Century" and therefore remains an advocacy priority for the AMA. In 2018, the AMA continued to be involved with like-minded advocates on how to best work together to address the health impacts of climate change.

Secretariat continued to engage with the Climate and Health Alliance on their 'Our Climate, Our Health' campaign, including attending webinars and meetings with relevant stakeholders.

In September, Dr Bartone met with the CEO of Doctors for the Environment Australia, Professor Kingsley Faulkner, in Perth. AMA representatives also attended several key Doctors for the Environment events in 2018, including the launch of the 'No Time For Games' and the 'Better Laws for a Better Planet' symposium. The AMA publicised the 'No Time for Games' campaign to our members, which focussed on alerting the community to the impacts of climate change on children's health.

In October, the AMA marked the release of the Intergovernmental Panel on Climate Change's 1.5° report with a media release, calling on the Government to seriously consider the report's findings on the significant impact of warming temperatures on human health. Another media release over the Christmas period focussed on the increasing health effects of climate change, and provided advice on how best to stay healthy during heatwaves.

Asylum Seeker and Refugee Health

Advocating for the health needs of asylum seekers and refugees was a priority for the AMA in 2018, with significant media attention on the AMA, particularly in the second half of the year.

The AMA lobbied the Government on behalf of individual refugees who needed to be brought to Australia from offshore detention for medical attention. Dr Bartone expressed the AMA's concern about the health of refugees and asylum seekers in offshore detention in meetings with the medical director for the company providing health services on Nauru, International Health and Medical Services (IHMS), and the Chief Medical Officer of the Department of Home Affairs.

In September, Dr Bartone wrote to new Prime Minister Scott Morrison, urging the Government to remove families and children from Nauru, calling the situation a "humanitarian emergency requiring urgent intervention". This was followed by significant lobbying of MPs and Senators across the political spectrum for short-term action and long-term solutions. AMA representatives, including paediatric representative Dr Paul Bauert, worked with other concerned groups to lobby at Parliament House throughout October. The latter part of the year's Parliamentary sitting period saw encouraging signs of progress towards evacuating refugees and asylum seekers requiring medical attention, and at the end of 2018 only seven asylum seeker children remained on Nauru.

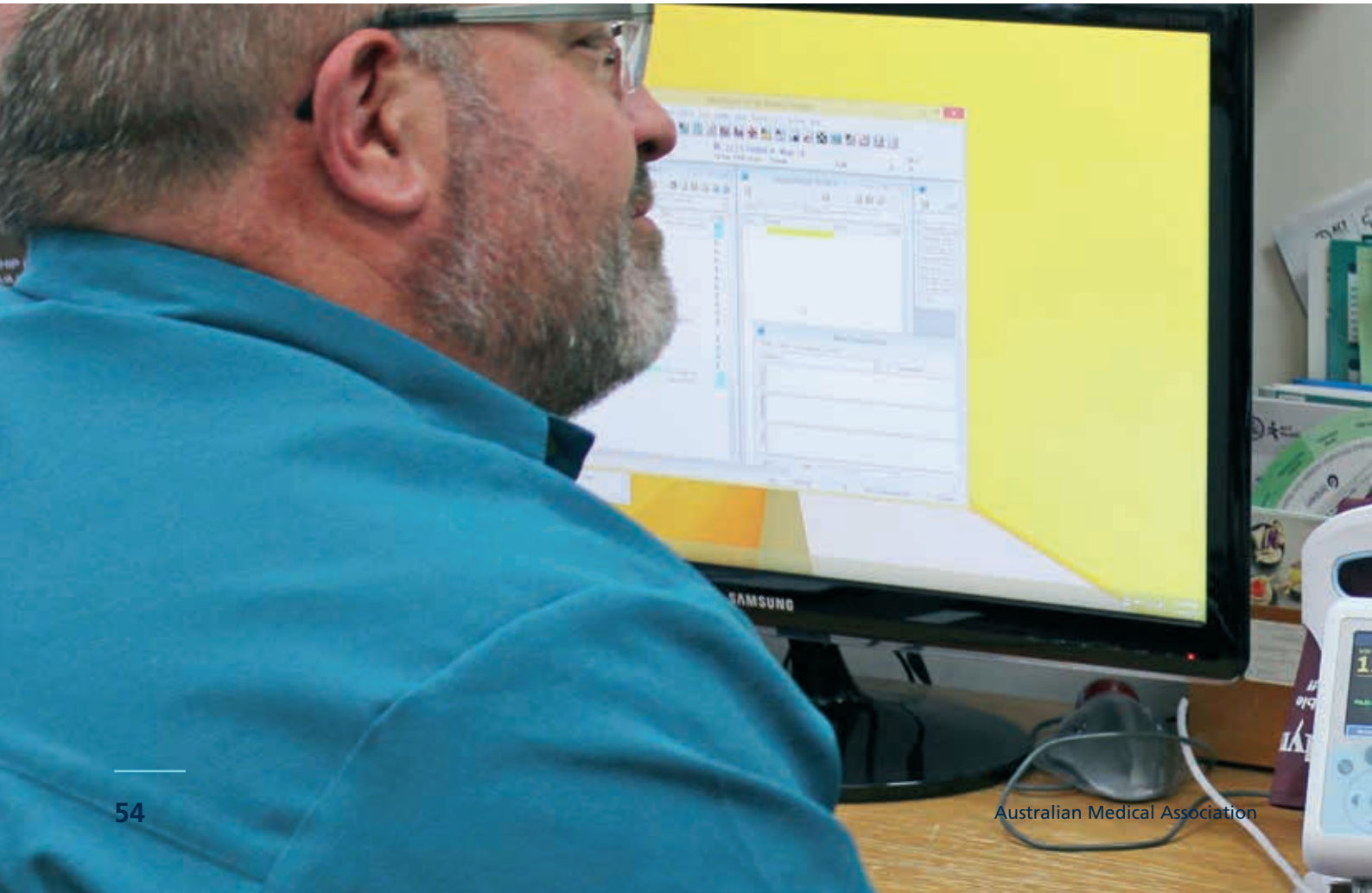
The AMA continues to advocate directly to the Department of Home Affairs and IHMS on cases brought to its attention. It has been a frustrating situation for the medical community, who almost universally have been strongly calling for those in need of medical care to be brought to Australia for appropriate treatment.

Vaccination and Immunisation

The AMA continued its longstanding and outspoken position on vaccination and immunisation issues in 2018. Early in the year, Dr Gannon publicly welcomed the introduction of the four-strain meningococcal vaccine to the National Immunisation Program. The AMA continued its opportunistic advocacy on the potential benefits of a No Fault Vaccine Compensation system, as well as monitoring changes and additions to publicly funded vaccines.

Firearms

Following the release of the AMA's Position Statement on *Firearms – 2017*, the AMA continued to strongly support gun safety measures, and was a formal observer on the Australian Gun Safety Alliance. The Alliance is a coalition of concerned organisations committed to ensuring that gun laws are upheld around the nation. Launched in September, the Alliance works to ensure that State and Territory Governments continue to comply with the National Firearms Agreement. Federal AMA also worked with AMA Tasmania to develop a submission to the Tasmanian Legislative Council on proposed changes to firearms laws, arguing strongly against the watering down of laws. In December the AMA was invited to attend a roundtable on firearms by Senator Linda Reynolds, Assistant Minister for Home Affairs. The roundtable will reconvene in 2019.



Contributions to Government Strategies and Plans

In 2018, the AMA continued to be involved in consultations on various Government strategies and action plans. The AMA's input to these consultation processes typically involves a written submission based on existing policy and/or participation in face-to-face consultations. These included:

- *National Alcohol Strategy 2018–2026*
- *National Men's Health Strategy 2020–2030*
- *National Women's Health Strategy 2020–2030*
- *National Tobacco Strategy*

List of Submissions

- Submission to the Department of Infrastructure, Regional Development and Cities' 2018 Inquiry into the *National Road Safety Strategy 2011–2020* (February)
- Submission to the Australian and New Zealand Ministerial Forum on Food Regulation's *Review of Fast Food Menu Labelling Schemes* (March)
- Submission to the Food Regulation Standing Committee's Consultation on the policy options targeted consultation paper: *Pregnancy warning labels on packaged alcoholic beverages* (June)
- Submission to the Senate Legal and Constitutional Affairs Legislation Committee's Inquiry into *the Criminal Code and Other Legislation Amendment (Removing Commonwealth Restrictions on Cannabis) Bill 2018* (June)

- Submission to the Senate Community Affairs Legislation Committee's Inquiry into the *Social Services Legislation Amendment (Drug Testing Trial) Bill 2018* (July)
- Submission to the Senate Select Committee's *Inquiry into the Obesity Epidemic in Australia* (July)
- Submission to the Australian Commission on Safety and Quality in Healthcare's Consultation on the National Safety and Quality Health Service Standards' user guide for health services providing care for people with mental health issues (July)
- Submission to the Australian National Audit Office's Performance Audit of Closing the Gap in Indigenous disadvantage (September)
- Submission to the Food Regulation Standing Committee's *Inquiry into Labelling of Sugars on Packaged Foods and Drinks* (September)
- Submission to the Aboriginal and Torres Strait Islander Health Reference Group (A&TSIHRG) of the MBS Review Taskforce's consultation on the recommendations for in-scope MBS items (September)
- Submission to the Department of Health's *Five Year Review of the Health Star Rating System: Options for System Enhancements* (December)

10.

Ethics

Guidelines and Position Statements

Guidelines for Doctors on Managing Conflicts of Interest in Medicine 2018

Conflicts of interest in medicine have the potential to undermine public trust and confidence in the profession if not managed appropriately. The AMA developed a new set of guidelines that expand on the AMA ***Code of Ethics***, assisting doctors in appropriately identifying and managing actual and potential conflicts of interest in the practice of medicine. The guidelines range from defining, identifying, and disclosing interests to determining whether an actual or perceived conflict of interest exists, resolving the conflict, disclosing interests to patients, and avoiding or reducing the potential for conflicts of interest to develop.

Guidelines on Doctors' Relationships with Industry 2018

It is vital that doctors and healthcare-related industries work collaboratively to improve health care through the development of, and access to, new and better therapeutic products, treatments and services. It is essential, however, that doctors manage such relationships appropriately to avoid actual and perceived conflicts of interest that can undermine public confidence and trust in the medical profession. Doctors' relationships with industry should be guided by the primacy of patient care and should:

- reflect core professional values such as transparency, accountability, trust, and fairness;
- not compromise, or be perceived to compromise, doctors' professional judgment and professional integrity;
- be open and transparent, able to withstand public and professional scrutiny, meet public and professional standards and expectations, and adhere to relevant legislative and regulatory requirements;
- promote effective stewardship and responsible use of healthcare resources; and
- promote professional autonomy and clinical independence.

The updated *Guidelines on Doctor's Relationships with Industry 2018* encapsulate and promulgate these principles and values, providing guidance on a range of issues including:

- industry marketing and promotion;
- medical education and professional education and training;
- industry sponsored research, meetings, activities, and training;
- key opinion leaders;
- remuneration for services;
- product samples;
- dispensing by doctors;
- interactions with industry representatives; and
- relationships with other medical service and health service providers.

WMA Declaration of Seoul on Professional Autonomy and Clinical Independence 2018

The AMA recently adopted the updated World Medical Association (WMA) *Declaration of Seoul on Professional Autonomy and Clinical Independence 2018*. Professional autonomy and clinical independence allow individual doctors to have the freedom to exercise their professional judgment in the care and treatment of patients without undue or inappropriate influence by outside parties or individuals.

This Declaration promulgates the critical nature of professional autonomy and clinical independence as essential elements in the delivery of high-quality health care for the benefit of patients and society.

Submissions

- Australian and New Zealand Intensive Care Society. *ANZICS Consultation Draft. The ANZICS Statement on Death and Organ Donation;*
- Australian Health Practitioner Regulation Agency. *Preliminary Consultation Paper. Review of the Guidelines for Advertising Regulated Health Services;*
- Expert Panel on Religious Freedom. *Religious Freedom Review;*
- Marie Stopes Australia. *Draft White Paper. Hidden Forces. Shining a Light on Reproductive Coercion*;
- Medical Board of Australia. *Preliminary Consultation Paper. Draft, Revised Good Medical Practice: A Code of Conduct for Doctors in Australia;*
- Medical Board of Australia. *Public Consultation Paper. Draft, Revised Good Medical Practice: A Code of Conduct for Doctors in Australia;*
- Medical Board of Australia. *Public Consultation Paper. Draft, Revised Guidelines on Sexual Boundaries in the Doctor-Patient Relationship;*
- Medical Council of New Zealand. *Draft, Revised Statement on Safe Practice in an Environment of Resource Limitation*.

World Medical Association Working Groups

The AMA regularly participates on World Medical Association (WMA) Working Groups charged with developing or revising select WMA Statements, Resolutions or Declarations. In 2018, the AMA served on the following WMA Working Groups:

- Medically Indicated Termination of Pregnancy;
- Pseudoscience and Pseudotherapies;
- International Code of Medical Ethics.

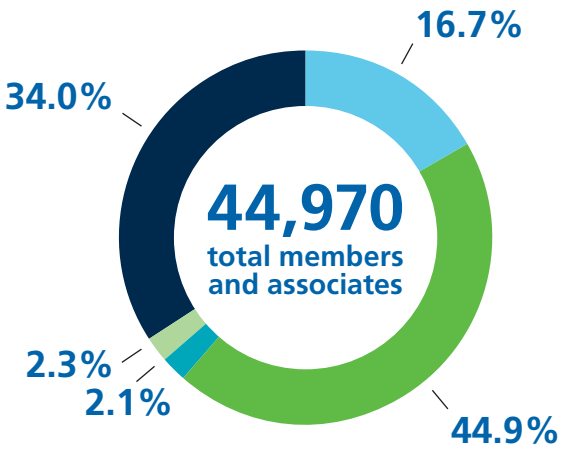
11.

Membership Services

Membership numbers

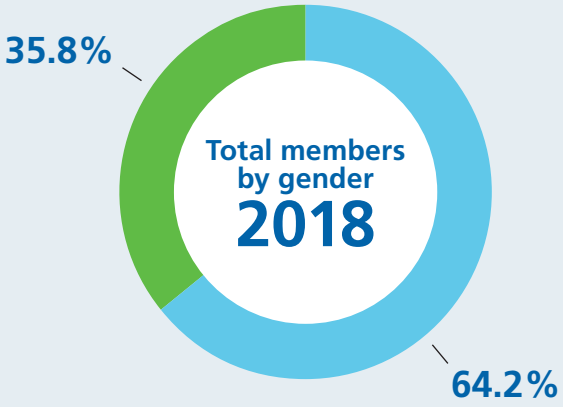
Membership by type:

Type	Members
Doctor in Training	7,516
GP, non-GP specialist, CMO	20,215
Retired from Practice	1,014
Other, academic, administration, & study leave	914
Total	**29,659**
Associate medical student members	15,311



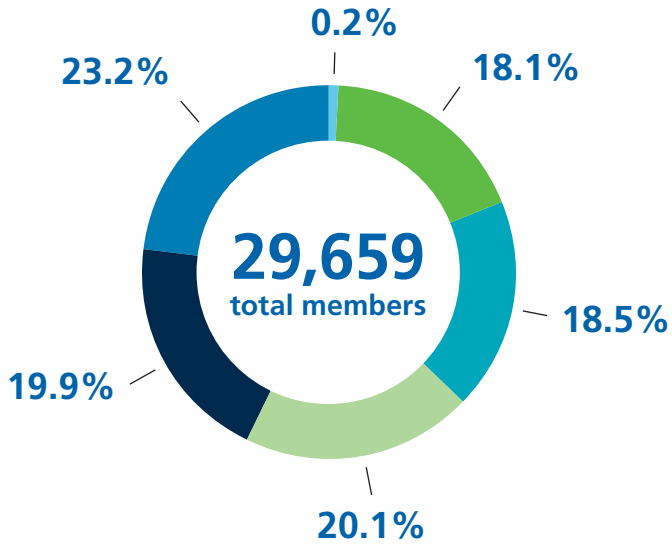
Membership by Gender:

Gender	Members
Male	19,040
Female	10,619



Membership by Age

Age Group	Members
<25	75
25-34	5,355
35-44	5,478
45-54	5,968
55-65	5,906
>65	6,877
Total	**29,659**



"My goal is to represent and serve the members of our association and continue building a strong membership that provides us with a powerful lobbying platform."

Dr Shaun Rudd, GP, Member of more than 20 years

Medical Student e-newsletter

A new quarterly e-newsletter was launched in March 2018 that includes information pertinent to medical students, along with news of AMA advocacy, member-only benefits, and career advice. Since its launch, the e-newsletter has proved to be a popular publication among student members with a total open rate of 71 per cent and engagement rate of 17 per cent, with no members unsubscribed.

AMA Career Service

ama.com.au/careers

The AMA Career Service delivers career-related information and support to doctors, medical students, and others with an interest in practising medicine.

With excellence and relevance as the cornerstones of the Career Service, its objectives are to provide information, learning, and career support and coaching that meets individuals' specific needs, regardless of their career stage or location.

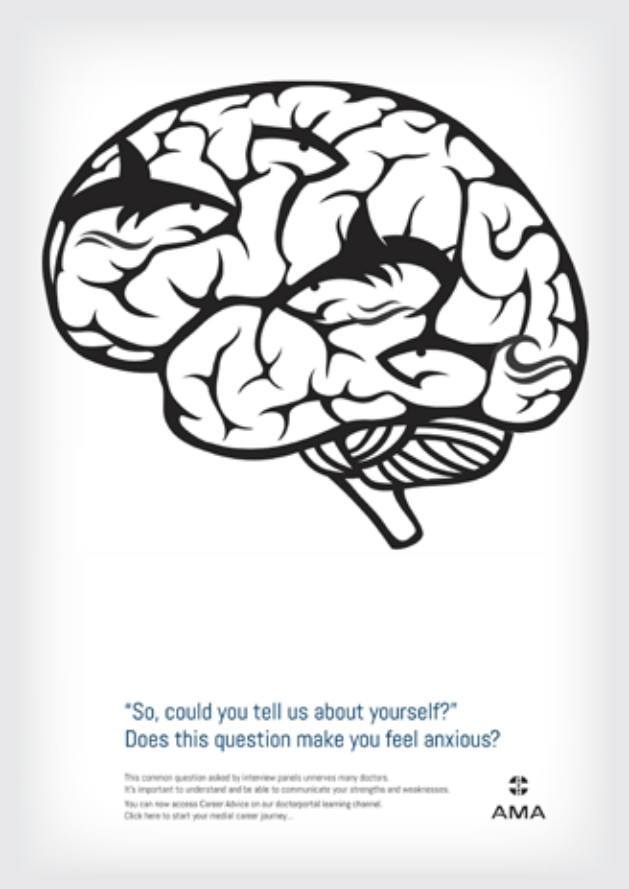
Service delivery

- **The Career Service web resource (ama.com.au/careers)** attracted 400,000 viewers to the site between July 2017 and August 2018, making it the most popular section on the AMA website.

  The site hosts information about the most frequently asked questions regarding the study and practice of Medicine, including the Specialty Training Pathways Guide – a resource enabling users to research specialties or compare the key attributes of all 64 medical specialties, such as entry requirements, cost, and positions available.
- **Responding to enquiries from IMGs and OTDs** – a high proportion of email enquiries received by the Service are from medical students and doctors outside Australia.
- **Personalised medical career counselling and coaching**. The Careers Adviser supports doctors with a host of issues – reviewing CVs and other documents for job and specialty training applications, one-on-one career counselling for career planning at any stage, and coaching for interview preparation.
- **Interactive learning modules** are now available via doctorportal Learning. The contemporary technology is easily accessible on remote devices. The experience is more meaningful in that it also educates the user about the doctorportal Learning resources from which they can benefit significantly and, on numerous occasions, via the wide range of professional development education modules available.
- **Close collaboration** with AMA marketing and membership teams in each State and Territory fosters the delivery of excellent services that are relevant to their members and promotes Service offerings through direct and indirect communications.

Engagement satisfaction

"I have finally been successful in obtaining a position back in medicine. Thank you for all of your time and effort in helping me get back into medicine with your resources and constant encouragement." – Satisfied member



doctorportal Learning

dplearning.com.au

doctorportal Learning is a CPD tracking and learning management platform that provides 24/7 accessibility to high quality, peer-reviewed and evidence-based online modules, that help our members remain competitive as medical professionals. This resource is free to members as a benefit of membership.

In 2018, the doctorportal Learning Catalogue was expanded to include more than 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:

- Access to Unapproved Therapeutic Goods, Cat 2 activity, ACRRM and RACGP accredited
- Basic Suturing Cat 2 activity, accredited with ACEM, ACRRM, ANZCA, CICM by Osler
- Concussion in Sport Self-directed Learning MJA article Dr David Hughes, Lisa Elkington, Silvia Manzanero
- Infant Feeding and Parental Health AMA Position Statement, Cat 2 activity, ACRRM and RACGP accredited
- Blood Borne Viruses (BBVs) 2017, AMA Position Statement, Cat 2 activity, ACRRM and RACGP accredited
- AMA Code of Ethics, AMA Position Statement, Cat 2 activity, ACRRM and RACGP accredited
- A Good Life: An end of life conversation worth having, Alfred Health and Kontentlabs, Cat 2 activity, ACRRM and RACGP accredited
- Medicare Billing Compliance, DoH, Cat 2 activity, ACRRM and RACGP accredited
- Writing a Medical CV for medical employment, training and advisory roles, paid module with CV template
- Doctors Acting as Medical Witnesses, AMA Guidelines, Cat 2 activity, ACRRM and RACGP accredited
- Listing events i.e. AMA National Conference 2018, accredited with ACRRM

A new doctorportal Learning website will be launched in 2019 that will be user friendly, engaging with personalised learning content, and easy to navigate platform targeted towards AMA members and non-members.

AMA National Conference

The 2018 AMA National Conference – the annual showpiece of the Federal AMA – was a great success.

A major change to the Conference this year was the introduction of all-day policy debates designed to promote greater grassroots policy discussion and development. State and Territory AMAs and the Practice Group Councils submitted topics and issues that were debated from the floor of the Conference.

Topics debated included contemporary issues in health care and the medical profession, from environmental sustainability in health care to gender equity, e-cigarettes, rural health, and more, giving delegates the opportunity to guide the work of the AMA's councils and committees.

The Conference also brought together a panel of six past Presidents of the AMA, interviewed by Dr Michael Gannon. The past Presidents reflected on the big political issues of their time – ranging from the medical indemnity crisis of the early 2000s to e-health and scope of practice boundary disputes with pharmacists.

The election of a new President and Vice President of the AMA took place at the Conference, with incoming leaders Dr Tony Bartone (President) and Dr Chris Zappala (Vice President) taking up their position until National Conference 2020. As the first GP President for four years, Dr Bartone outlined his commitment to working in the interests of general practice and its patients, especially on the issues that are highly relevant to general practice such as access to mental health care and access to aged care.

Nobel Peace Prize recipient, Associate Professor Tilman Ruff, delivered a sobering and powerful anti-nuclear weapons speech at the AMA Leadership Development Dinner. In his address, he spoke of the devastating impact of nuclear weapons and urged attendees to harness the power of evidence-based arguments and personal stories to inspire and lead on change.

The AMA recognised leaders in medicine through various AMA awards. Dr John Murtagh, who wrote the John Murtagh's General Practice – the pre-eminent reference textbook for general practitioners, medical students, and registrars – was recognised with the AMA's highest honour, the AMA Gold Medal. Dr David Rivett OAM, a country GP with decades of service to both his community and the State and Federal AMAs, was recognised with the President's Award.

The full recipient list is as follows:

- Doctor in Training of the Year – Dr Mikaela Seymour
- Excellence in Healthcare – Prof Elizabeth Elliott
- Gold Medal – Dr John Murtagh AM
- Indigenous Scholarship Winner – Mr Pirpantji Rive-Nelson
- President's Award – Dr David Rivett OAM
- Woman in Medicine – Dr Judith Goh

The Conference also featured awards recognising excellence in medical research, public health, lobbying and advocacy, and communication, and inducted five new members in the AMA Roll of Fellows. In recognition of their outstanding contributions to both the medical profession and the AMA – A/Prof Beverley Rowbotham, A/Pro Robert Parker, Dr Elizabeth Gallagher, Dr Nigel Stewart and Dr Chris Zappala – were added to the Roll.

This Conference proved to be a successful and engaging Conference with delegates welcoming the new changes to the Conference format.

12.

Financial Report

General Purpose Financial Report
Australian Medical Association Limited and Controlled Entities
ABN 37 008 426 793
For the financial year 31 December 2018

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 – Until 29 November 2018
Ophthalmologist

Dr Elizabeth Feeney
MBBS, MHL, FANZCA, FAICD, FAMA
Investment Committee member
Anaesthetist
(Board member until 27 May 2018)

Dr Michael Gannon
MBBS, MRCPI, FRANZCOG, FAMA
President, AMA
Obstetrician and Gynaecologist
(Board member until 27 May 2018)

Dr Anthony Bartone
MBBS, FRACGP, MBA, FAMA
Vice President – Until 27 May 2018
President, AMA – From 27 May 2018
General Practitioner

Prof Geoffrey Dobb
BSc (Hons), MBBS, FRCP, FRCA, FANZCA, FCICM, FAMA
Investment Committee member
Intensive Care Physician
(Board Member until 27 May 2018)

Dr Danielle McMullen
MBBS (Hons), FRACGP, DCH, GAICD
Investment Committee member
General Practitioner
(Board Member from 27 May 2018)

A/Professor Rosanna Capolingua
MBBS, FAMA, FAICD
Deputy Chair – From 20 December 2018
Investment Committee member
General Practitioner
(Board Member from 27 May 2018)

A/Professor Gino Pecoraro
MBBS, FRANZCOG, FAMA
Chair – From 29 November 2018
Obstetrician & Gynaecologist
(Board member from 19 June 2018)

Dr Bavahuna Manoharan
BSc (BioMed), MBBS, GAICD
Audit and Risk Committee member
Medical Administration 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

Dr Christopher Zappala
MBBS (Hons), GAICD, GCAE, AMusA, MHM, MD, FRACP, FAMA
Vice President – From 27 May 2018
Thoracic and Sleep Physician

Principal activities

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

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

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

The AMA undertakes advocacy on behalf of its members, and provides services and communications to its members. Through its subsidiaries, it publishes and circulates the *Medical Journal of Australia* and coordinates the provision of medical services to all medical practitioners and medical students. The consolidated Group owns property and investment assets to support revenue earned from membership subscriptions.

Financial results

Review and result of operations

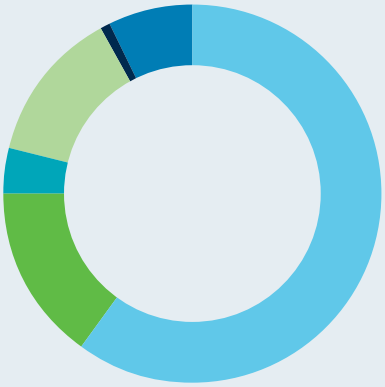
In 2018, the consolidated Group recorded a profit for the year of $4.3 million (2017: $0.04 million). The sale of AMA House, which was recorded in March 2018, resulted in a net profit on sale of $5 million that contributed to the large increase in profit compared to 2017.

The consolidated comprehensive income for the year was $3.3 million (2017: $0.3 million). In 2018, the Group recorded a significant fall in the fair value of long-term investments at fair value of $1.4 million (2017: increase of $0.2 million). These changes in fair value are reflective of movements in global equity markets and are unrealised gains or losses.

Revenue

Compared to 2017, total revenue from operations, excluding profit from sale of AMA House, has increased by 1.4% (2017: 3.2%) to $22.4 million (2017: $22 million) compared to 2017.

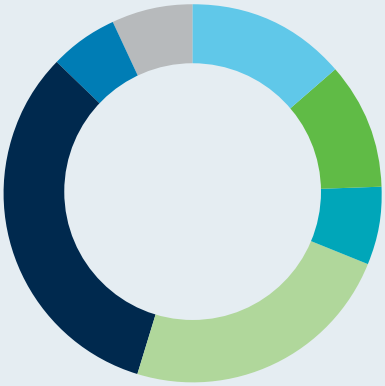
Graph 1 – Distribution of revenue in 2018 (excluding sale of property)



Membership subscriptions	60%
Database and data sales	15%
Editorial	4%
Commercial and member services	13%
Rental	1%
Doctors' Health Services	7%

Expenses

Graph 2 – Distribution of expenses (excluding income tax)



Commercial and member services	14%
Database and data	11%
Doctors' Health Services	7%
Publications	24%
Advocacy and policy	33%
Subsidies	6%
Property	7%

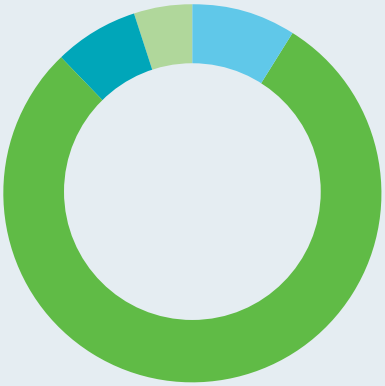
Total expenses (excluding income tax) decreased by 1.6% (2017: decreased 1.5%) to $21.9 million (2017: $22.3 million).

Review of financial position

Net assets increased 16.7% to $22.8 million compared to prior year (2017: increased 1.3% to $19.6 million). The significant increase in retained profits is from net gain on sale of AMA House. Proceeds from the sale of property have been invested in long-term equity markets, changing the distribution of assets in the Group in 2018 from a heavy weighting in domestic investment property to long-term investments in the global equity markets.

Assets

Graph 3 – Distribution of assets

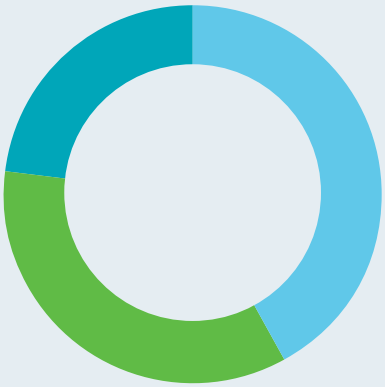


Property, plant and equipment, investment properties, and intangibles	9%
Cash and investments	79%
Receivables	7%
Other	5%

The sale of AMA House has resulted in a change in the taxonomy of the Group's assets with a decrease in property and increase in long-term investment holdings.

Liabilities

Graph 4 Distribution of liabilities



Payables	42%
Employee benefits	35%
Other	23%

Liabilities remain unchanged compared to 2017.

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 reviewed its strategic objectives and developed a new set of strategic objectives for 2018–2019.

The strategic objectives support the AMA's mission of Leading Australia's Doctors – Promoting Australia's Health. The Board also agreed to emphasise Diversity and Inclusion as part of its strategic objectives going forward.

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

Auditor's independence declaration

A copy of the Auditor's independence declaration as required under s307C of the *Corporations Act 2001* is set out on page 113.

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 2018, insuring the directors of the company and all executive officers of the Group against a liability incurred by such a director or executive officer to the extent permitted by the *Corporations Act 2001*.

Information on Directors

The Board is comprised of 11 medically qualified Directors and includes the President and Vice President, one Director nominated by each State and Territory AMA and one Director nominated by the AMA Council of Doctors in Training. The Chair is elected from among the Directors. Dr Iain Dunlop stepped down as Chair on 29 November 2018 and was replaced by A/Prof Gino Pecoraro.

Under the Constitution, the Directors are required to be appointed based on 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 22.

Directors meeting attendance

During the period 1 January 2018 to 31 December 2018 the Board met on 13 occasions, seven were face to face meetings and six were via videoconference.

The Audit and Risk Committee met 4 times. Two members of the Committee are Directors and one is an independent appointment.

The Investment Committee met 8 times. All three members of the Committee are Directors.

The following tables summarise the meeting attendance of the Directors and Committee members during 2018, noting the number of meetings each Director/ Committee member was eligible to attend and attended.

Board Meetings

	Eligible to attend	Attended
Dr Tony Bartone	13	13
Dr Chris Zappala	13	12
A/Prof Rosanna Capolingua	8	8
Dr Iain Dunlop	13	13
Dr Bavahuna Manoharan	13	12
Dr Helen McArdle	13	12
Dr Danielle McMullen	8	8
A/Prof Gino Pecoraro	8	8
Dr Gary Speck	13	13
Dr Danika Thiemt	13	12
Dr Peter Sharley	13	13
Prof Geoff Dobb	4	3
Dr Elizabeth Feeney	4	4
Dr Michael Gannon	4	3

Audit and Risk Committee

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

Investment Committee

	Eligible to attend	Attended
Dr Gary Speck	8	8
Professor Geoff Dobb (until 26 May 2018)	4	3
Dr Elizabeth Feeney (until 26 May 2018)	4	4
A/Prof Rosanna Capolingua (from 27 May 2018)	4	4
Dr Danielle McMullen (from 27 May 2018)	4	3

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

Signed in accordance with a resolution of the Directors.

Dr Anthony Bartone
President
Australian Medical Association Limited

A/Prof Gino Pecoraro
Chair
Australian Medical Association Limited

Statement of comprehensive income

For the year ended 31 December 2018

	Note	Consolidated 2018 $'000	Consolidated Restated 2017 $'000
Revenue		**21,667**	21,510
Other income		**6,022**	540
	2	**27,689**	22,050
Expenses			
Employment		**(12,217)**	(12,008)
Publications		**(1,820)**	(1,734)
Database and data		**(45)**	(32)
Advocacy and policy		**(1,362)**	(1,387)
Subsidies	2	**(1,258)**	(1,233)
Commercial and member services		**(111)**	(250)
Doctors Health Services		**(1,486)**	(1,587)
Property and occupancy		**(1,092)**	(1,055)
Depreciation and amortisation		**(365)**	(807)
Administration	2	**(2,148)**	(2,162)
		(21,904)	(22,255)
Profit before income tax		**5,785**	(205)
Income tax credit/(expense)	4	**(1,454)**	244
Profit for the year		**4,331**	39
Other comprehensive income			
Changes in fair value of investments at fair value through other comprehensive income		**(1,372)**	222
Income tax relating to these items		**316**	–
Other comprehensive income for the year, net of tax		**(1,056)**	222
Total comprehensive income for the year		**3,275**	261

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

Statement of financial position

as at 31 December 2018

	Note	Consolidated 2018 $'000	Consolidated Restated 2017 $'000
Assets			
Current assets			
Cash and cash equivalents	5	**4,127**	3,615
Trade and other receivables	6	**1,835**	1,483
Inventories	7	**25**	35
Prepayments	8	**469**	398
Other investments	9	**254**	–
Assets held for sale	17	**959**	9,728
Total current assets		**7,669**	15,259
Non-current assets			
Other investments	9	**16,933**	4,540
Intangible assets	10	**607**	519
Investment properties	11	**–**	495
Property, plant and equipment	12	**786**	1,358
Deferred tax assets	13	**508**	1,260
Total non-current assets		**18,834**	8,172
Total assets		**26,503**	23,431
Liabilities			
Current Liabilities			
Trade and other payables	14	**2,349**	2,483
Employee benefits	15	**1,130**	1,220
Income tax payable	16	**9**	–
Total current liabilities		**3,488**	3,703
Non-current liabilities			
Employee benefits	15	**145**	133
Total non-current liabilities		**145**	133
Total liabilities		**3,633**	3,836
Net assets		**22,870**	19,595
Equity			
Retained earnings		**23,704**	19,373
Reserve		**(834)**	222
Total equity		**22,870**	19,595

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

Statement of changes in equity

for the year ended 31 December 2018

Consolidated	Retained earnings	Reserve	Total Equity
	$'000	$'000	$'000
At 1 January 2017	19,334	–	19,334
Profit for the year (restated)	39	–	39
Other comprehensive income (restated)	–	222	222
Total comprehensive income for the year (restated)	39	222	261
At 31 December 2017 (restated)	**19,373**	**222**	**19,595**
Profit for the year	**4,331**	–	**4,331**
Other comprehensive income	–	**(1,056)**	**(1,056)**
Total comprehensive income for the year	**4,331**	**(1,056)**	**3,275**
At 31 December 2018	**23,704**	**(834)**	**22,870**

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

Statement of cash flows

for the year ended 31 December 2018

	Note	Consolidated 2018 $'000	Consolidated 2017 $'000
Cash flow from operating activities			
Receipts from membership subscriptions		**13,435**	13,553
Other receipts from customers		**10,180**	11,067
Payment to suppliers and employees		**(25,077)**	(24,540)
Interest received		**1,007**	347
Income tax (paid)/refund		**(378)**	173
Net cash flow (used in)/from operating activities		**(833)**	600
Cash flow from investing activities			
Payments for intangible assets	10	**(240)**	(471)
Payments for property, plant and equipment	12	**(145)**	(706)
Proceeds from property, plant and equipment		**15,749**	–
Payments for other investments		**(14,019)**	(283)
Net cash flow from/(used in) investing activities		**1,345**	(1,460)
Net increase/(decrease) in cash held		**512**	(860)
Cash and cash equivalents at the beginning of the year		**3,615**	4,475
Cash and cash equivalents at the end of the year		**4,127**	3,615

(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*.

New accounting standard adopted by the Group

AASB 9 replaces the provisions of AASB 139 that relate to the recognition, classification and measurement of financial assets and liabilities, derecognition of financial instruments and impairment of financial assets. The impact of AASB 9 is disclosed in Note 28.

The Group classifies its financial assets in the following measurement categories:

- Those to be measured subsequently at fair value; and
- Those to be measured at amortised cost.

The classification depends on the entity's business model for managing the financial assets and the contractual terms of the cash flows.

For assets measured at fair value, gains and losses will either be recorded in profit or loss or OCI. For investments in equity instruments that are not held for trading, this will depend on whether the Group has made an irrevocable election at the time of initial recognition to account for the equity investment at fair value through other comprehensive income (FVOCI).

The Group reclassifies debt investments when and only when its business model for managing those assets changes.

Basis of preparation

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

Australian Accounting Standards set out accounting policies that the AASB has concluded will result in financial statements containing relevant and reliable information about transactions, events and conditions. 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 11 April 2019.

Notes to and forming part of the financial statements

Note 1 Statement of Significant Accounting Policies (continued)

(a) Principles of consolidation

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

Where controlled entities have entered or left the Group during the year, the financial performance of those entities is included only for the period of the year that they were controlled. A list of controlled entities is contained in Note 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.

(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.

Note 1 Statement of Significant Accounting Policies (continued)

(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.

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).

Note 1 Statement of Significant Accounting Policies (continued)

(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.

(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.

Note 1 Statement of Significant Accounting Policies (continued)

(h) Investments and other financial assets

(i) Classification

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

The Group has made an irrevocable election at the time of initial recognition to account for its equity investments at fair value, that are not held for trading, through other comprehensive income.

Financial assets at fair value through profit of loss (FVPL)

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

(ii) Recognition and derecognition

Regular way purchases and sales of financial assets are recognised on trade-date, the date on which the Group commits to purchase or sell the asset. Financial assets are derecognised when the rights to receive cash flows from the financial assets have expired or have been transferred and the group has transferred substantially all the risks and rewards of ownership.

(iii) Measurement

At initial recognition, the Group measures a financial asset at its fair value plus, in the case of a financial asset not at fair value through profit or loss (FVPL), transaction costs that are directly attributable to the acquisition of the financial asset. Transaction costs of financial assets carried at FVPL are expensed in profit or loss. Financial assets with embedded derivatives are considered in their entirety when determining whether their cash flows are solely payment of principal and interest.

Debt instruments

Subsequent measurement of debt instruments depends on the Group's business model for managing the asset and the cash flow characteristics of the asset. There are three measurement categories into which the group classifies its debt instruments:

- **Amortised cost:** Assets that are held for collection of contractual cash flows where those cash flows represent solely payments of principal and interest are measured at amortised cost. Interest income from these financial assets is included in finance income using the effective interest rate method. Any gain or loss arising on derecognition is recognised directly in profit or loss and presented in other gains/(losses) together with foreign exchange gains and losses. Impairment losses are presented as separate line item in the statement of profit or loss.
- **FVOCI:** Assets that are held for collection of contractual cash flows and for selling the financial assets, where the assets' cash flows represent solely payments of principal and interest, are measured at FVOCI. Movements in the carrying amount are taken through OCI, except for the recognition of impairment gains or losses, interest income and foreign exchange gains and losses which are recognised in profit or loss. When the financial asset is derecognised, the cumulative gain or loss previously recognised in OCI is reclassified from equity to profit or loss and recognised in other gains/(losses). Interest income from these financial assets is included in finance income using the effective interest rate method. Foreign exchange gains and losses are presented in other gains/(losses) and impairment expenses are presented as separate line items in the statement of profit or loss.

Note 1 Statement of Significant Accounting Policies (continued)

(h) Investments and other financial assets (continued)

(iii) Measurement (continued)

- FVPL: Assets that do not meet the criteria for amortised cost or FVOCI are measured at FVPL. A gain or loss on a debt investment that is subsequently measured at FVPL is recognised in profit or loss and presented net within other gains/(losses) in the period in which it arises.

Equity instruments

The Group subsequently measures all equity investments at fair value. Where the Group's management has elected to present fair value gains and losses on equity investments in OCI, there is no subsequent reclassification of fair value gains and losses to profit or loss following the derecognition of the investment. Dividends from such investments continue to be recognised in profit or loss as other income when the Group's right to receive payments is established.

Changes in the fair value of financial assets at FVPL are recognised in other gains/(losses) in the statement of profit or loss as applicable. Impairment losses (and reversal of impairment losses) on equity investments measured at FVOCI are not reported separately from other changes in fair value.

(iv) Impairment

The Group assesses on a forward looking basis the expected credit losses associated with its debt instruments carried at amortised cost and FVOCI. The impairment methodology applied depends on whether there has been a significant increase in credit risk.

For trade receivables, the Group applies the simplified approach permitted by AASB 9, which requires expected lifetime losses to be recognised from initial recognition of the receivables.

Note 1 Statement of Significant Accounting Policies (continued)

(i) Financial liabilities

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

(j) Cash and cash equivalents

Cash and cash equivalents include cash on hand, deposits held at call with banks, other short-term highly liquid investments with original maturities of three months or less and bank overdrafts.

(k) Trade and other receivables

Trade and other receivables include amounts due from customers for goods sold and services performed in the ordinary course of business. Receivables expected to be collected within 12 months of the end of the reporting period are classified as current assets. All other receivables are classified as non-current assets.

(l) Trade and other payables

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

(m) Inventories

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

(n) Property, plant and equipment

Recognition and measurement

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

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

Note 1 Statement of Significant Accounting Policies (continued)

(n) 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:

	2018	2017
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)

(o) Intangible assets

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

Subsequent expenditure

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

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:

	2018	2017
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.

(p) 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:

	2018	2017
Buildings	**2.5% – 4%**	2.5% – 4%

Note 1 Statement of Significant Accounting Policies (continued)

(q) 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.

(r) Impairment

Financial assets

Trade receivables

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

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

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

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

Investments

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

Note 1 Statement of Significant Accounting Policies (continued)

(s) 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.

(t) 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.

(u) Parent entity financial information

The financial information for the Parent Entity, as disclosed in Note 26 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)

(v) 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.

(w) Comparative figures

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

Note 2 Revenue and Expenses

	Note	Consolidated 2018 $'000	Consolidated Restated 2017 $'000
Revenue			
Membership subscription		**12,408**	12,343
Database and data sales		**3,085**	3,224
Editorial		**738**	603
Commercial and member services		**2,631**	2,778
Doctors Health Services		**1,486**	1,587
Rental		**290**	628
Interest		**22**	94
Interest from investments at fair value through other comprehensive income		**1,007**	253
Other income			
Profit on sale of assets	17	**5,339**	–
Other revenue including recoveries		**683**	540
		27,689	22,050
Expenses			
Contributions to employee superannuation plans		**950**	921
Cost of goods sold		**27**	39
Repairs and maintenance		**59**	191
Subsidies			
Subsidies to AMA States and Territories		**1,219**	1,195
Other subsidies		**39**	38
		1,258	1,233
Administration			
Loss on disposal of assets		**43**	18
Insurance		**157**	163
Travel and accommodation		**517**	500
Other		**1,431**	1,481
		2,148	2,162

Note 3 Auditor's Remuneration

Audit services		
Auditors of the Group		
RSM Australia Partners		
– Audit of financial report	**64**	60
Other services		
Auditors of the Group		
RSM Australia Pty Ltd		
– Taxation services	**20**	16
	84	76

Note 4 Income tax (expense)/credit

	Consolidated	
	2018	2017
	$'000	$'000
Current tax (expense)/credit		
Current tax on profits for the year	**(9)**	–
Prior year adjustments	**(377)**	–
	(386)	–
Deferred tax credit/(expense)		
Origination and reversal of temporary differences	**(1,214)**	404
Prior year adjustments	**146**	(160)
	(1,068)	244
Total income tax credit/(expense) in income statement	**(1,454)**	244
(Profit)/loss before income tax	**(5,785)**	205
Income tax using the domestic corporation tax rate of 27.5%	**(1,591)**	56
Increase in income tax expense due to:		
Mutual expenditure	**(3,780)**	(3,742)
Non-deductible expenses	**(6)**	(7)
Sundry	**(12)**	(15)
	(3,798)	(3,764)
Decrease in income tax expense due to:		
Mutual income	**4,072**	4,031
Fully franked dividends	**68**	1
Sundry	**26**	80
	4,166	4,112
Net change in income tax	**(1,223)**	404
Under provision for prior year – current tax expense	**(377)**	–
Under provision for prior year – deferred tax expense	**146**	(160)
	(231)	(160)
Income tax credit/(expense)	**(1,454)**	244
Attributable to:		
Continuing operations	**(1,454)**	244

Note 5 Cash and Cash Equivalents

	Note	Consolidated 2018 $'000	Consolidated 2017 $'000
Cash at bank	18(b)	**1,506**	2,359
Short-term deposits	18(b)	**2,620**	1,254
Cash on hand		**1**	2
Total Cash and cash equivalents	18	**4,127**	3,615

Note 6 Trade and other receivables

	Note	Consolidated 2018 $'000	Consolidated 2017 $'000
Trade receivables		**652**	653
Provision for impairment		**(10)**	(11)
		642	642
Other receivables		**1,193**	841
Total Trade and other receivables	18	**1,835**	1,483

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

Balance at 1 January	**(11)**	(13)
Unused amounts reversed	**1**	2
Balance at 31 December	**(10)**	(11)

(i) Classification as trade and other receivables

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

Note 7 Inventories

	Note	Consolidated 2018 $'000	Consolidated 2017 $'000
Finished goods		**25**	35
Total Inventories		**25**	35

Note 8 Prepayments

	Note	Consolidated 2018 $'000	Consolidated 2017 $'000
Prepayments		**469**	398
Total Prepayments		**469**	398

Note 9 Other investments

	Note	Consolidated 2018 $'000	Consolidated 2017 $'000
Current assets			
Financial assets at amortised cost			
Short-term deposits	18(a)	**254**	–
Total Current		**254**	–
Non-current assets			
Financial assets at fair value through other comprehensive income			
Managed securities fund	18(b)	**16,933**	4,540
Total Non-current		**16,933**	4,540
Total Other investments		**17,187**	4,540

(a) Financial assets at amortised cost

(i) Classification of financial assets at amortised cost

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

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

Note 9 Other investments (continued)

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

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

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

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

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

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

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

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

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

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

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

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

Note 10 Intangible assets

	Consolidated	
	2018	**2017**
	$'000	**$'000**
Membership database – at cost	**–**	733
Less: Accumulated amortisation	**–**	(727)
	–	6
Website – at cost	**–**	56
Less: Accumulated amortisation	**–**	(56)
	–	–
Computer software – at cost	**830**	653
Less: Accumulated amortisation	**(263)**	(358)
	567	295
IT Project developments – at cost	**40**	218
Less: Accumulated amortisation	**–**	**–**
	40	218
Total Intangible assets	**607**	519

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 2017					
Opening written down value	7	–	93	–	100
Additions	–	–	253	218	471
Amortisation	(1)	–	(51)	–	(52)
Closing written down value	6	–	295	218	519
31 December 2018					
Opening written down value	**6**	**–**	**295**	**218**	**519**
Additions	**–**	**–**	**163**	**77**	**240**
Disposals	**(4)**	**–**	**(32)**	**–**	**(36)**
Transfer	**–**	**–**	**255**	**(255)**	**–**
Amortisation	**(2)**	**–**	**(114)**	**–**	**(116)**
Closing written down value	**–**	**–**	**567**	**40**	**607**

Note 11 Investment properties

	Consolidated	
	2018	2017
	$'000	$'000
Units 1 and 2 Tourism House – at cost	–	2,610
Less: Accumulated depreciation	–	(2,115)
Total Investment properties	–	495

Movements in carrying amounts:

Consolidated	Units 1 and 2 Tourism House	Total
	$'000	$'000
31 December 2017		
Opening written down value	600	600
Expensing of capitalised leased costs	–	–
Depreciation	(105)	(105)
Closing written down value	495	495
31 December 2018		
Opening written down value	**495**	**495**
Depreciation	**(35)**	**(35)**
Transfer to Assets held for sale	**(460)**	**(460)**
Closing written down value	–	–

Units 1 and 2 of Tourism House have been classified as assets held for sale during the year, refer to Note 17 for further details.

Note 12 Property, plant and equipment

	Consolidated	
	2018	2017
	$'000	$'000
Buildings, AMA House – at cost	–	–
Add: Net capitalised lease expenditure	–	230
Less: Accumulated depreciation	–	–
	–	230
Property, Parap Rd, Parap – at cost	**381**	381
Less: Accumulated depreciation	**(71)**	(62)
	310	319
Office furniture – at cost	**1,156**	1,521
Less: Accumulated depreciation	**(931)**	(1,185)
	225	336
Office equipment – at cost	**220**	202
Less: Accumulated depreciation	**(120)**	(120)
	100	82
Fixtures and fittings – at cost	**83**	293
Less: Accumulated depreciation	**(42)**	(49)
	41	244
Computer hardware – at cost	**350**	333
Less: Accumulated depreciation	**(265)**	(213)
	85	120
Assets less than $300 – at cost	**26**	67
Less: Accumulated depreciation	**(26)**	(67)
	–	–
Personal computer network – at cost	**46**	41
Less: Accumulated depreciation	**(21)**	(14)
	25	27
Total Property, plant and equipment	**786**	1,358

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. It is the Group's accounting policy to obtain a valuation every 5 years.

Notes to and forming part of the financial statements

Note 12 Property, plant and equipment (continued)

Movement in carrying amount: Consolidated	Opening written down value $'000	Additions $'000	Disposals $'000	Depreciation $'000	Capitalised lease costs $'000	Note 22 Capitalised lease costs expensed $'000	Transfer (to)/from Assets held for sale $'000	Closing written down value $'000
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
31 December 2018								
Leasehold land, AMA House	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Buildings, AMA House	**230**	**–**	**–**	**–**	**–**	**(13)**	**(217)**	**–**
Property, Parap Rd Parap	**319**	**–**	**–**	**(9)**	**–**	**–**	**–**	**310**
Office furniture	**336**	**36**	**–**	**(79)**	**–**	**–**	**(68)**	**225**
Office equipment	**82**	**52**	**(5)**	**(29)**	**–**	**–**	**–**	**100**
Fixture and fittings	**244**	**5**	**–**	**(10)**	**–**	**–**	**(198)**	**41**
Computer hardware	**120**	**45**	**(2)**	**(78)**	**–**	**–**	**–**	**85**
Assets < $300	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**
Personal computer network	**27**	**7**	**–**	**(9)**	**–**	**–**	**–**	**25**
	1,358	**145**	**(7)**	**(214)**	**–**	**(13)**	**(483)**	**786**

Notes to and forming part of the financial statements

Note 13 Deferred tax assets and liabilities

Consolidated	Deferred Tax Assets		Deferred Tax Liabilities		Total	
	2018	2017	2018	2017	2018	2017
	$'000	$'000	$'000	$'000	$'000	$'000
Property, plant and equipment	**(8)**	386	**–**	–	**(8)**	386
Accruals	**58**	45	**–**	–	**58**	45
Employee benefits	**140**	123	**–**	–	**140**	123
Investments	**316**	(61)	**–**	–	**316**	(61)
Other	**2**	2	**–**	–	**2**	2
Carried forward losses	**–**	765	**–**	–	**–**	765
Total Deferred tax assets/(liabilities)	**508**	1,260	–	–	**508**	1,260

Movement in temporary differences:

Consolidated	Property, plant and equipment	Accruals	Employee benefits	Investments	Other	Carried forward losses	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
31 December 2017							
Opening written down value	431	124	134	(22)	3	346	1,016
Recognised in income statement	(45)	(79)	(11)	(39)	(1)	419	244
Closing written down value	386	45	123	(61)	2	765	1,260
31 December 2018							
Opening written down value	**386**	**45**	**123**	**(61)**	**2**	**765**	**1,260**
Recognised in income statement	**(394)**	**13**	**17**	**61**	**–**	**(765)**	**(1,068)**
Recognised in equity	**–**	**–**	**–**	**316**	**–**	**–**	**316**
Closing written down value	**(8)**	**58**	**140**	**316**	**2**	**–**	**508**

Note 14 Trade and other payables

	Note	Consolidated 2018 $'000	Consolidated 2017 $'000
Trade payables		**447**	403
Other payables and accruals		**1,065**	1,131
Income in advance		**837**	949
Total Trade and other payables	18	**2,349**	2,483

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

Note 15 Employee benefits

	Note	Consolidated 2018 $'000	Consolidated 2017 $'000
Current			
Long service leave provision		**554**	513
Annual leave provision		**576**	707
		1,130	1,220
Non-current			
Long service leave provision		**145**	133
Total Employee benefits		**1,275**	1,353

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

Note 16 Income tax payable

	Note	Consolidated 2018 $'000	Consolidated 2017 $'000
Income tax payable		**9**	–
Total Income tax payable		**9**	–

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

	Note	Consolidated 2018 $'000	Consolidated 2017 $'000
Assets held for sale			
AMA House		–	9,728
Tourism House		**959**	–
		959	9,728

(a) AMA House

(i) Description

The sale of AMA House was settled 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.

(ii) Profit on sale of AMA House

	Note	$'000
Profit on sale before capital gains tax	2	5,339
Capital gains tax, net of utilised carried forward tax losses		(377)
Net profit on sale after capital gains tax		4,962

(b) Tourism House

(i) Description

Tourism House was made available for sale during the year and the sale contract exchanged, with settlement occurring in January 2019.

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	
		2018	2017
	Note	$'000	$'000
Financial assets			
Cash and cash equivalents	5	**4,127**	3,615
Trade and other receivables	6	**1,835**	1,483
Financial assets at amortised costs	9	**254**	–
Financial assets at fair value through other comprehensive income	9	**16,933**	4,540
		23,149	9,638

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

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

Note 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	
		2018	2017
	Note	$'000	$'000
Variable rate instruments			
Financial assets			
Cash at bank	5	**1,506**	2,359
		1,506	2,359
Fixed rate instruments			
Financial assets at amortised costs			
Short term deposits	5	**2,620**	1,254
		2,620	1,254

(ii) Currency risk

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

(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

Financial assets	Note	Consolidated 2018 $'000	Consolidated 2017 $'000
Non-current assets			
Financial assets at fair value through other comprehensive income			
Managed fund – Australian securities		**10,587**	2,796
Managed fund – International securities		**6,346**	1,744
	9	**16,933**	4,540

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 at fair value through profit or loss or other comprehensive income.

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.

(c) Liquidity risk

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

(d) Fair values versus carrying amount

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

(e) Capital management

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

Note 19 Operating leases

Leases as lessee:

Non-cancellable operating lease rentals are payable as follows:

	Consolidated	
	2018	2017
	$'000	$'000
Not later than 1 year	**10**	11
Later than 1 year but not later than 5 years	**–**	10
	10	21

Leases as lessor:

The Group leases out its investment property under operating leases (see Note 11), which has been classified as asset held for sale during the financial year.

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

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

Note 20 Commitments

	Consolidated	
	2018	2017
	$'000	$'000
Expenditure commitment:		
Not later than 1 year	**947**	437
Later than 1 year but not later than 5 years	**2,129**	847
	3,076	1,284
Commitments receivable		
Not later than 1 year	**54**	24
Later than 1 year but not later than 5 years	**92**	–
	146	24

Notes to and forming part of the financial statements

Note 21 Controlled entities

	Consolidated	
	2018	**2017**
Parent entity	**2018**	2017
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
Doctorportal Learning Pty Ltd	**1**	–
	8	7

The controlled entities, Australasian Medical Publishing Company Proprietary Limited, AMA Pty Limited, AMA NT Pty Ltd, Actraint No. 110 Pty Limited, Doctors Health Services Pty Ltd and Doctorportal Learning Pty Ltd, are incorporated in Australia and are 100% controlled by the Australian Medical Association Limited. A new company, Doctorportal Learning Pty Ltd, was incorporated in November 2018.

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 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	
	2018	**2017**
	$'000	**$'000**
Total remuneration	3,426	3,034

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.

Notes to and forming part of the financial statements

Note 23 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	
	2018	2017
	$	$
The Indigenous Peoples' Medical Scholarship Trust Fund	**80,557**	119,864
The AMA Indigenous Medical Scholarship Foundation	**119,581**	71,701
	200,138	191,565

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

Note 24 Subsequent events

Other than the sale of Tourism House, refer Note 17(b) for further detail, 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 25 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
- Doctorportal Learning 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.

Note 25 Company details (continued)

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 Pty Limited also acts as trustee for the Indigenous Peoples' Medical Scholarship Trust Fund and the AMA Indigenous Medical Scholarship Foundation.

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

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.

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

Note 26 Parent entity

As at, and throughout the financial year ended 31 December 2018, 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.

	2018 $'000	Restated 2017 $'000
(a) Financial information		
(Loss)/profit before income tax (expense)/credit	**(123)**	(163)
Income tax (expense)/credit *	**(555)**	244
(Loss)/profit for the year	**(678)**	81
Changes in fair value of investments at fair value through other comprehensive income (including income tax)	**(951)**	222
Total comprehensive (loss)/profit	**(1,629)**	303

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

Statement of financial position		
Assets		
Current assets	**4,975**	4,641
Non-current assets	**25,651**	15,412
Total assets	**30,626**	20,053
Liabilities		
Current liabilities	**2,524**	1,579
Non-current liabilities	**14,281**	3,024
Total liabilities	**16,805**	4,603
Equity		
Retained earnings	**14,550**	15,228
Reserve	**(729)**	222
Total equity	**13,821**	15,450

(b) Guarantees

A guarantee was provided in the prior year by the Australian Medical Association Limited in favour of the Council of the City of Sydney, which existed for the rent of the Australasian Medical Publishing Company Pty Ltd (AMPCo) premises at Town Hall House. This guarantee is currently held on its own under AMPCo.

(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 27 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 NT Pty Limited, Actraint No 110 Pty Limited, AMA Property Trust, Doctors Health Services Pty Limited and Doctorportal Learning Pty Limited.

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 2018 %	Equity holding 2017 %
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
Doctorportal Learning Pty Ltd	Ordinary	**100**	–

Note 28 Restatement of Comparatives – Adoption of AASB 9 *Financial Instruments*

This note explains the impact of the adoption of AASB 9 *Financial Instruments* on the Group's financial statements.

(a) Impact on the financial statements

As a result of the changes in the Group's accounting policies, prior year financial statements had to be restated.

The following tables show the adjustments recognised for each individual line item.

Balance sheet (extract)	31 December 2017		
	As originally presented $'000	AASB 9 $'000	Restated $'000
Current assets			
Cash and cash equivalents	3,615	–	3,615
Trade and other receivables	1,483	–	1,483
Inventories	35	–	35
Prepayments	398	–	398
Assets held for sale	9,728	–	9,728
Non-current assets			
Available for sale financial assets	4,540	(4,540)	–
Financial assets at fair value through other comprehensive income (FVOCI)	–	4,540	4,540
Intangible assets	519	–	519
Investment properties	495	–	495
Property, plant and equipment	1,358	–	1,358
Deferred tax assets	1,260	–	1,260
Total assets	23,431	–	23,431
Current liabilities			
Trade and other payables	2,483	–	2,483
Employee benefits	1,220	–	1,220
Non-current liabilities			
Employee benefits	133	–	133
Total liabilities	3,836	–	3,836
Net assets	19,595	–	19,595
Equity			
Retained earnings	19,595	(222)	19,373
Reserve	–	222	222
Total equity	19,595	–	19,595

Note 28 Restatement of Comparatives – Adoption of AASB 9 *Financial Instruments* (continued)

(a) Impact on the financial statements (continued)

	31 December 2017		
	As originally presented $'000	AASB 9 $'000	Restated $'000
Statement of profit or loss and other comprehensive income (extract)			
Revenue	22,272	(222)	22,050
Expenses	(22,255)	–	(22,255)
Profit before income tax	17	(222)	(205)
Income tax credit	244	–	244
Profit for the year	261	(222)	39
Other comprehensive income			
Changes in fair value of investments at FVOCI	–	222	222
Total comprehensive income for the year	261	–	261

(b) AASB 9 Financial Instruments

AASB 9 replaces the provisions of AASB 139 that relate to the recognition, classification and measurement of financial assets and financial liabilities, derecognition of financial instruments, impairment of financial assets and hedge accounting.

The adoption of AASB 9 Financial Instruments resulted in changes in accounting policies and adjustments to the amounts recognised in the financial statements. The new accounting policies are set out in note 1(h) above.

The total impact on the Group's retained earnings is as follows:

	31 December 2017		
	As originally presented $'000	AASB 9 $'000	Restated $'000
As at 31 December 2016	19,334	–	19,334
Profit for the year	261	(222)	39
As at 31 December 2017	19,595	(222)	19,373

Directors' Declaration

The Directors of the Company declare that:

1. the financial statements and notes, set out on pages 73 to 111 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 2018 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 11th day of April 2019.

Dr Tony Bartone
President
Australian Medical Association Limited

Dr Gino Pecoraro
Chair
Australian Medical Association Limited

Auditors' Independence Declaration

RSM Australia Partners

Equinox Building 4, Level 2, 70 Kent Street Deakin ACT 2600
GPO Box 200 Canberra ACT 2601

T +61 (0) 2 6217 0300
F +61 (0) 2 6217 0401

www.rsm.com.au

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 2018, 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

RSM AUSTRALIA PARTNERS

G Stenhouse

GED STENHOUSE
Partner

Canberra, Australian Capital Territory
Dated: 12 April 2019

Independent Audit Report

RSM Australia Partners

Equinox Building 4, Level 2, 70 Kent Street Deakin ACT 2600
GPO Box 200 Canberra ACT 2601

T +61 (0) 2 6217 0300
F +61 (0) 2 6217 0401

www.rsm.com.au

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 2018, 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 2018 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 2018, 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: 12 April 2019

AMA

42 Macquarie Street Barton ACT 2600
Telephone: 02 6270 5400
Facsimile: 02 6270 5499
Email: ama@ama.com.au

www.ama.com.au